Patient Information Form

DAYNES EYE & LASIK

Patient

Name: _____ SSN: _____

Birthdate: _____ Gender: ☐ Male ☐ Female Patient Phone: _____

Primary Care / Referring Physician: _____

Pharmacy: _____

Responsible Party

☐ Same as Patient ☐ Use as Emergency Contact

Name: _____ SSN: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

City, State Zip Code

Email Address: _____ Date of Birth: _____

Okay to contact you by email? ☐ YES ☐ No

Employer Information

Occupation: _____ Employer: _____

Work Address: _____ Employer Phone: _____

_____ Okay to call you at work? ☐ YES ☐ No

_____

City, State Zip Code

Emergency Contact

Name: _____

Phone: _____

Relationship: _____

Insurance Information

Insurance Name: _____

Vision Insurance: _____

Member ID: _____

Group Number: _____

Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request. A copy has been made for you to review on the front desk.

I hereby acknowledge receipt of the Notice of Privacy practices given to me.

_____

Signature *Date*