

CHART# _____

BRIGGS OPHTHALMOLOGY & ASSOCIATES, SC
PATIENT INFORMATION

(PLEASE BE SURE TO SIGN ALL APPROPRIATE AREAS FOUND ON BOTH SIDES OF THIS PAPER)

PATIENT NAME: _____ SS# _____

ADDRESS: _____ DATE OF BIRTH: _____ AGE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS TO RECEIVE A COPY OF YOUR EXAMS: _____

HOME PHONE: _____ ALTERNATE PHONE: _____ MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED RACE _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY/STATE/ZIP _____ WORK # _____

IN CASE OF AN EMERGENCY: NAME: _____ PHONE # _____

Please provide an additional contact person and phone number to reach in case we need to contact you regarding your appointment:

NAME: _____ PHONE#: _____

INSURANCE INFORMATION: Any changes? YES NO

PRIMARY INSURANCE _____ Are you the SUBSCRIBER? Yes No

If not who is? Please list their full name, and what is their date of birth? _____

SECONDARY INSURANCE _____ Are you the SUBSCRIBER? Yes No

If not who is? Please list their full name, and what is their date of birth? _____

PLEASE INDICATE PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

CITY/ STATE/ZIP: _____ ALTERANTE PHONE#: _____

AUTHORIZATION FOR PAYMENT

I request that payment of authorized Medicare/commercial Insurance Co. benefits be made to me or on my behalf to the above named doctor for any services furnished by that physician. I authorize my medical information about me to be released to my Insurance Company and its agents, Information needed to determine these benefits payable for related services.

X _____
Signature Date

I authorize that payment of authorized Medigap benefits be made either to me or on my behalf to the doctor named above for any services furnished to me by the physician. I authorize any holder of medical information about me to release to my Medigap company any information needed to determine these benefits or the benefits payable for related services.

X _____
Signature Date

I understand that I will take full responsibility for any unpaid balances and stay in communication with the office.

X _____
Signature Date

for office use only: **KSB** **BJK** **AB**

chart# _____
confirmed by: _____

BRIGGS OPHTHALMOLOGY & ASSOCIATES, SC

1) AUTHORIZATION FOR MEDICAL RELEASE:

I hereby give my consent to Briggs Ophthalmology & Associates to release information about my medical/ocular condition to the following people:

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

X _____
Signature Date

2) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of this office's Notice of Privacy Practices.

Please print your name

X _____
Signature Date

For office use only:

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining the acknowledgement.

_____ Other (Please specify): _____

In lieu of patient signature, I _____, a staff member of Briggs Ophthalmology & Associates

state that _____ was given a copy of our current Notice of Privacy Practices.

X _____ Date _____

for office use only: KSB RJK AB

chart# _____
confirmed by: _____