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 BJK AB

chart#_____
confirmed by:_____