Name_____ Date of Birth_____/_____/_____

Address_____ SS# _____

_____ Male _____ Female _____
City State Zip Code

Home Phone (_____) _____Cell (_____) _____Work (_____) _____

Email Address _____

Please circle any phone number(s) where we may communicate with you. This includes leaving messages on voicemail or answering machine. These messages may be regarding upcoming appointments, lab results, etc.

Pharmacy Name/Phone Number _____

Employer _____

Spouse or Parent's Name _____ Phone (_____)_____

Emergency Contact _____ Phone(_____)_____

Who do we thank for referring you to our practice? _____

How did you hear about us? TV Radio Newsletter Flyer Internet Newspaper

Insurance Information

Primary _____ Policy #_____

Insured Name _____ DOB _____/_____/_____

If you are a Medicare policy holder: Are you still employed Yes____ No _____
Is your spouse still employed Yes ____ No _____

Secondary _____ Policy # _____

Insured Name _____ DOB _____/_____/_____
(IF DIFFERENT THAN PATIENT)

***Our office will file primary insurance claims with contracted insurance companies. Please be advised that the services rendered may or may not be covered under your individual policy. Claims remaining unpaid after 60 days will become the responsibility of the patient. Co Pays & Deductibles are due at the time of service.**
***I authorize the release of medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Charleston Cornea & Refractive Surgery, p.a.**
***I hereby acknowledge that I have received a copy of the Charleston Cornea & Refractive Surgery.p.a. Notice of privacy practices.**

Sign: Patient or Guardian _____ **Date:** _____