Moreland EYECARE

Amber R. Moreland, O.D.

# PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Sex: _____M _____F SS# _____

Occupation: _____ Employer: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone #_____ Cell Phone #_____ Home Phone # _____

Emergency Contact:_____ Phone # _____

Email Address: _____ Preferred Language: _____

**(If patient is a minor, please supply parent's email)**

Please circle Ethnicity: Hispanic Not Hispanic Unknown or Not Reported

Please circle your Race: White Black or African American Asian American Indian

Pacific Islander More than one Race Other Unknown or Not Reported

Please list other members of your family that are patients at Moreland EyeCare:

_____

## INSURANCE INFORMATION

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason.

| | | | |
|---|---|---|---|
| Primary Medical Insurance Company | Policy Holder | SS# | Date of Birth |
| Secondary Medical Insurance Company | Policy Holder | SS# | Date of Birth |
| (1) Vision Insurance Company | Policy Holder | SS# | Date of Birth |
| (2) Vision Insurance Company | Policy Holder | SS# | Date of Birth |

**I, the undersigned, authorize the release of any information relating to all claims for benefits submitted on my behalf. I authorize the payment of medical benefits directly to the physician.**

**Resp. Party Signature:** _____**Relationship:**_____**Date**:_____

# CONSENT FORMS

Patient Name: _____ Date of Birth: _____

## HIPPA PRIVACY ACT

I have received for review the Notice of Privacy Practices from Moreland EyeCare. I understand that this Notice of Privacy Practices describes the types of uses, the sharing of my protected health information that will occur in my treatment, payment of my bills, or in the health care operations of Moreland EyeCare, and my rights as they relate to the privacy of my health information. I understand that I may request and receive a copy of the Notice of Privacy Practices.

_____ Date: _____

***(Signature of Patient or Personal Representative)***

_____

***(Printed Name of Patient or Personal Representative)***

_____

***(Description of Personal Representative's Authority)***

### Please fill out the following section if the patient is a minor:

### Legal Guardian Confirmation/Consent

I, _____, confirm legal guardianship of the following minor,

***(Please print Parent's or Legal Guardian's Name)***

_____.

***(Please Print Minor's Name)***

I give consent for the following individuals to bring in the minor for service, medication, and treatment.

| **INDIVIDUAL** | **RELATIONSHIP TO MINOR** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ Date: _____

***(Signature of Parent or Legal Guardian)***