TYSON EYE

THANK YOU FOR CHOOSING TYSON EYE

Provider: Appt. Time:

Location: Appt. Date

This form is intended to expedite the process of new patient entry into our systems. For assistance please call (239) 542-2020.

PATIENT INFORMATION

Your Name: Date:

Social Security Number: Account Number:

Street Address:

City: State: Zip Code:

Date of Birth: Age: Marital Status: Gender:

Mobile Phone: Home Phone: Work Phone:

Spouse Name: First: Middle: Last:

Northern Address: Street Address: City: State: Zip:

Northern Home Phone: Email Address:

Race: ___Native American | ___Asian/Pacific Islander | ___African American | ___Hispanic | ___Caucasian | ___Other

Referring Physician: Primary Care Physician:

EMPLOYMENT INFORMATION

Employer Name: Employer Phone Number:

Employer Address: Occupation:

Emergency Contact Name: Relationship: Phone:

How did you hear about Tyson Eye?

___ Drove by Building ___ Billboard ___ Direct Mail ___ Insurance Company ___ Television ___ Internet Search

___ Newspaper ___ Physician ___ Phone Book ___ Vets Administration ___ Word of Mouth ___ Social Media

Please list anyone with whom we have your permission to discuss your care, including your emergency

Name: Relationship:

Name: Relationship:

Name: Relationship:

Do we have permission to leave messages regarding your eye health on your home answering machine? ◯ Yes ◯ No

INSURANCE INFORMATION

Primary Insurance Company:

Address:

Subscriber / Member's Name

Subscriber's Date of Birth: Subscriber's Social Security Number:

Policy / ID Number: Group Number:

Secondary Insurance Company:

Address:

Subscriber / Member's Name

Subscriber's Date of Birth: Subscriber's Social Security Number:

Policy / ID Number: Group Number:

Vision Insurance Company:

Address:

Subscriber / Member's Name

Subscriber's Date of Birth: Subscriber's Social Security Number:

Policy / ID Number: Group Number:

MINORS INFORMATION-PLEASE COMPLETE IF PATIENT IS UNDER THE AGE OF EIGHTEEN

Father's Name: Mother's Name:

Employer: Employer:

Work Phone: Work Phone:

I give permission for Tyson Eye of Cape Coral Eye Center, PA to treat my minor child.

Child's Name:

Parent / Guardian Signature: Date:

I authorize any holder of medical or other information about me, to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, carriers, any commercial insurance companies, and the billing agent of Tyson Eye of Cape Coral Eye Center, PA, any information needed for this or related Medicare and other insurance claims. I permit a copy of this authorization to be used in place of an original and request payment of Medicare insurance benefits, either to myself, or the party who accepts the assignment. All insurance benefits are to be made payable to Cape Coral Eye Center, PA. I further agree that I will be responsible for any balances and on-covered services that remain unpaid.

ALL OF THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLDEGE.

Patient's Signature: Date:

Signature if other than beneficiary: Date:

Reason patient is unable to sign:

Please list all medications, herbs, vitamins and over the counter medications you are currently taking.

Name of Medication	Dose	Frequency	Route of Admin. (e.g., orally, injection, nasal spray)	Reason for Taking (e.g., diabetes, blood pressure)

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Address: _____
Street Address City State Zip

For Office Use Only:

Technician Signature:	Date:	Technician Signature:	Date:
Technician Signature:	Date:	Technician Signature:	Date:
Technician Signature:	Date:	Technician Signature:	Date:
Technician Signature:	Date:	Technician Signature:	Date:

TYSON EYE

239•542•2020 | TysonEye.com

Medication List

Patient Name:

Gender: Male Female

DOB:

12/21