



# OPPENHEIMER EYE CLINIC



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## PATIENT INFORMATION

### GENERAL INFORMATION

PATIENT NAME: \_\_\_\_\_ SEX:  MALE  FEMALE

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ BIRTH STATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

HOME #:( ) CELL #:( ) WORK #:( )

EMAIL: \_\_\_\_\_ SPECIAL NEEDS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_ \*RACE: \_\_\_\_\_ \*ETHNICITY:  HISPANIC  NOT HISPANIC

\*\*RACE/ETHNICITY ARE MORE VULNERBALE TO CERTAIN EYE DISEASES, AND IDENTIFYING THOSE PATIENTS CAN HELP US IMPROVE YOUR EYE CARE\*\*

EMERGENCY CONTACT NAME & PHONE #: \_\_\_\_\_

### ACCOUNT REPSONSIBLE (IF PATIENT IS A MINOR OR DIFFERENT FROM PATIENT)

MOTHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

GUARDIAN'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS(city,state,zip): \_\_\_\_\_

PHONE #:( ) WORK#:( ) CELL#:( )

### INSURANCE INFORMATION NO VISION NO MEDICAL

VISION INSURANCE: \_\_\_\_\_

VISION INSURANCE MEMBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

VISION INSURANCE MEMBER ID #: \_\_\_\_\_

PATIENT RELATIONSHIP TO MEMBER: SPOUSE | CHILD | OTHER(explain)

PRIMARY MEDICAL INSURANCE: \_\_\_\_\_

PRIMARY MEMBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MEDICAL INSURANCE ID # \_\_\_\_\_

MEDICAL INSURANCE GROUP# \_\_\_\_\_

PATIENT RELATIONSHIP TO MEMBER: SPOUSE | CHILD | OTHER(explain)

SECONDARY MEDICAL INSURANCE: \_\_\_\_\_

SECONDARY MEMBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SECONDARY INSURANCE ID #: \_\_\_\_\_

PATIENT RELATIONSHIP TO MEMBER: SPOUSE | CHILD | OTHER(explain)

### MEDICAL INFORMATION RELEASE AND HIPAA

A copy of Oppenheimer's Notice of Privacy Practices is available for review upon request. Please review this document if you desire, and sign below that you have had the opportunity to review it. Copies are available if you would like to take one with you.

I authorize the release of information, including diagnosis, records, examination rendered to me and information. This information may be release to the following person(s): \_\_\_\_\_

Information is not to be released to anyone. This release of information will remain in effect until terminated in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_