WELCOME TO EYE PHYSICIANS AND SURGEONS OF COLUMBIA, P.A.

PATIENT INFORMATION

Chart#_____ **Today's Date_____**

Patient Name: _____ _____Male _____Female

Date of Birth: _____ SSN: _____ Marital Status: _____

Address: _____

Employer & Occupation: _____ Work#: _____

Home #: _____ Cell #: _____

Email: _____ Language Spoken:_____

Race: _____ Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

Would you like to give someone access to your medical and/or financial records? ____Yes ____ No

Name: _____ Relationship: _____

Insurance Information: Do you have VSP, Physicians Eyecare Network, Physicians Eyecare Plan? Circle
Please provide medical policy holder information below: **Self Spouse Parent
Policy holder's name: _____Date of Birth: _____ SSN: _____

Primary Insurance:_____ Secondary Insurance: _____

Responsible party if other than self: _____Relationship:_____

May we leave detailed information including lab results on your voice mail? _____ YES _____ NO

Emergency Contact (friend or relative not living with you) Relationship:_____

Name: _____ Phone #: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. I understand the type and extent of services will be determined following an initial evaluation and thorough discussion with me. If there is any change in my medical status, I will inform my doctor. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Failure to resolve my financial responsibilities could result in collection action and/or dismissal from the practice.

***Refraction fees are not covered by most insurance companies. The refraction fee of $30.00 may be the responsibility of the patient.**

**** An additional fee will be charged for completion of highway and disability forms.**

I acknowledge receiving a copy of the Notice of Privacy Practices _____Initials

Signature:_____Date:_____