

Chattanooga Vision Center PLC

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PATIENT INFORMATION

Mr. / Mrs.: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____

Employer: _____ Work Phone: (____) _____

PATIENT REFERRED BY: Doctor (name): _____

Relative Friend Yellow Pages Member PPO/HMO Other (name): _____

Family Physician: _____

Insured/Responsible Party Information

Name: _____ Date of Birth: _____ Relationship: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work/CellPhone: (____) _____

Employer: _____ SS#: _____

Emergency Contact Name: _____ Contacts Phone Number: _____

DOES YOUR INSURANCE REQUIRE A REFERRAL? _____ IF SO, DID YOU GET ONE? _____ IF YOU ANSWERED NO, PLEASE SIGN STATING YOU UNDERSTAND YOU WILL BE RESPONSIBLE FOR THIS BILL:

Patient's Signature: _____ Date: _____

DISCLOSURE PROTECTED HEALTH INFORMATION

According to office policy, test results/release of medical information will be provided to the patient only. Please specify below whom information may be released to other than yourself. Please complete the information below & sign you name to verify permission.

Myself only Son/Daughter Husband/Wife Other (please specify) _____

May we leave messages at your:

Home answering machine Cell Phone Work Other (please specify) _____

I have received a copy of Chattanooga Vision Center's Privacy Notice explaining the uses and disclosures of my health information:

YES NO Patient Initials: _____

Medicare/Insurance: I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Drs. Reynolds Ridner or Hildebrand, for any services furnished me by that provider.

Patient Signature: _____ Date: _____