

COLUMBIA EYE CLINIC, P.A.  
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**PATIENT INFORMATION**

PLEASE PRINT

Patient Name \_\_\_\_\_ Home Tel. \_\_\_\_\_ Bus. Tel. \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ Sex: \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_ Address \_\_\_\_\_  
Street City State Zip

Race:  White  Black  Asian  American Indian or Alaskan Native  Native Hawaiian  Declined to Specify

Ethnicity:  Not Hispanic or Latino  Hispanic or Latino  Declined to Specify

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Method of Contact for Appointment Reminders:

Home Phone  Cell Phone  Text  Email

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Telephone \_\_\_\_\_

In Emergency Contact: \_\_\_\_\_  
Name Telephone Relationship

**RESPONSIBLE PARTY**

Name \_\_\_\_\_  Self  Parent  Other \_\_\_\_\_

Address \_\_\_\_\_ Home Tel. \_\_\_\_\_ Bus. Tel. \_\_\_\_\_  
Street City State Zip

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. However, financial agreement rests with you and not the insurance company. Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. for services rendered.

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

