RAND EYE INSTITUTE

PATIENT INFORMATION

Date:			**Were you referred by another Doctor?** Please circle one
Acct #:			**MD or OD** _____

LAST NAME:		FIRST NAME:		M.I.		Sal.	
ADDRESS 1:							
ADDRESS 2:							
CITY:		**STATE:**		**ZIP:**			
HOME PHONE:	()	**CELL PHONE:**		**WORK PHONE:**	()		
DATE OF BIRTH:		Sex		**SOCIAL SECURITY #:**			
EMAIL ADDRESS:				**RELIGION:**			
PRIMARY LANGUAGE:		**RACE:**		**ETHNICITY:**			

How would you like us to contact you? Please initial your selection(s) below.			
____ Home Phone	____Cell Phone	____Work Phone	____Email

By signing below I am authorizing the Rand Eye Institute to contact me via one of the contact methods above.

Emailing via the Patient Portal, Social Media, or other electronic means should NEVER be used for Emergency Situations. Email is strictly for communication purposes. For emergencies the physician/office can be reached at 954-782-1700.

X _____ _____
Date

INSURANCE INFORMATION

	INS CO.	ID #	GROUP #
PRIMARY:			
SECONDARY:			

INSURANCE AUTHORIZATION

I authorize and request my insurance company to pay directly to the Physician's and provider's of the Rand Eye Institute/Rand Surgical Pavilion the amount due to me in my pending claims for basic medical, major medical, and/or surgical treatment or services.

X _____ Date _____

How did you hear about us: Please circle one			
Friend/Family:		Optometrist/Ophthalmologist Visit	
Website/Internet	Ch. 25/Dr. Oz	Walgreens	Angie's List
Fox Sports	Comcast/Cable	ZocDoc	Urgent Care
Health Fair	Vision Screening	Lecture	Other:

Emergency Contact Information			
Name:		Relationship:	
Home Phone:		Cell Phone:	

Patient's Name:		Acct #:	

Occupation:		Employer:	
Address:			
City:		State:	Zip:
Spouse Name:			
Spouse Phone:		Spouse Employer:	

ALTERNATE ADDRESS					
ADDRESS 1:					
ADDRESS 2:					
CITY:		STATE:		ZIP:	

Authorization for Release of Medical Information

I authorize you to share my information with those listed below.

NAME:_____ PHONE: _____ RELATIONSHIP: _____

NAME:_____ PHONE: _____ RELATIONSHIP: _____

NAME:_____ PHONE: _____ RELATIONSHIP: _____

I, hereby, authorize the Physicians and Providers of the Rand Eye Institute/Rand Surgical Pavilion, to release to any and all parties as noted above on the Notice of Privacy Practices/Authorization for release of Medical Information, any information, including the diagnosis and the records of any treatment, examination or surgery rendered to me during the period of such medical care and/or surgical care.

X _____ Date _____

I acknowledge, I have **received**, **read**, and **understand** the Notice of Privacy Practices.

X _____ Date _____

By signing below I am confirming that all the information on both patient information sheets are correct, unless otherwise noted. If any of my insurance information is not correct/current and/or the Rand Eye Institute cannot be reimbursed due to uncovered charges, I acknowledge that I am responsible for payment in full.

X _____ Date _____