FORT LAUDERDALE EYE INSTITUTE/FORT LAUDERDALE RETINA INSTITUTE

PATIENT INFORMATION RECORD

(Please Print)

Patient's Legal Name: _____ Today's Date _____
First M.I. Last

Address: _____
Street City State Zip

Telephone: _____ Work Telephone: _____ Cell # _____ Email: _____

Patient's Date of Birth: _____ It is okay to confirm appt or leave message via phone _____ Sex: Male _____ Female _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Spouse's Name _____

Pt's Social Security #: _____ Primary Language _____

Are you currently employed? ❑ Yes ❑ No ❑ Retired Primary Doctor _____

Responsible Party: _____ Telephone: ( ) _____
First M.I. Last

Who referred you to Ft. Lauderdale Eye Institute? _____
(Friend, relative, doctor, newspaper, phone book, insurance plan, other)

Patient's Employer: _____ Telephone: ( ) _____

Occupation _____ Address _____
Street City State Zip

If necessary you may discuss my medical care with: Spouse(Name) _____ Children(Name) _____

Next of Kin: _____ Relationship _____ Res. Phone: ( ) _____ Work: ( ) _____

I. COMPLETE IF YOU ARE A MEDICARE PATIENT

Medicare Number: _____ Is Medicare Your Primary Insurance? _____
If Medicare is not Primary, Please Complete Section II and III)

Medicare Supplemental Insurance (if any): _____

Address: _____
Street City State Zip

Group Number: _____ Policy Number: _____

II. COMPLETE IF YOU ARE NOT A MEDICARE PATIENT

Is your insurance a: PPO _____ HMO _____ Other _____

III. IS PATIENT'S CONDITION RELATED TO:

❑ Yes/❑ No...Employment (current or previous)? ❑ Yes/❑ No...Auto accident? ❑ Yes/❑ No...Other accident?

GROUP

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Policy & Group Number: _____ Insured SS #: _____

Name of Insured: _____ Insured's Date of Birth: _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Student over 18 _____

Other (Please describe) _____

OFFICE POLICY REGARDING INSURANCE

We are happy to file all insurance claims for our patients. I understand that I am responsible for the payment of services rendered. I authorize any holder of medical or other information about me to be released for the purpose of billing my insurance. I understand that I am financially responsible for any co-pays, deductibles or non covered services. It is my obligation to have a referral if necessary from my primary doctor and to make sure that my doctor at FLEI/FLRI is on my insurance plan.

Signature _____ Date _____