

# Haik & Terrell Eye Clinic

**Patient** Soc. Sec. No. \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Marital Status \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Policy Holder** Soc. Sec. No. \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ D.O.B. \_\_\_\_\_

Street \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insurance Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

- Patient agrees to release of medical or other information to process claim  Yes  No
- Patient agrees to allow Haik & Terrell, LLC. to accept assignment of payment  Yes  No
- Patient gave office permission to leave a message on their answering machine  Yes  No

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