Haik & Terrell Eye Clinic

Patient Soc. Sec. No. _____

Last Name _____ First Name _____MI_____

Mailing Address _____

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. _____

Relationship to Patient _____ D.O.B. _____

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

Patient gave office staff permission to send them emails [ ] Yes [ ] No

Patient agrees to give Haik & Terrell, LLC permission to discuss medical conditions with the following person(s): _____ Relationship _____

Signature _____ **Date** _____