Eye Surgery Associates

Patient Information:

First Name: ______________________ MI ____
Last Name: ______________________

Nickname: ______________________

Address: ______________________

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Birthdate: ______________ ☐ Male ☐ Female

Social Security: ______________________

Home phone: ______________________

Cell phone: ______________________

Email: ______________________

☐ Divorced ☐ Separated ☐ Widow

☐ Single ☐ Married: Spouse Name______________

Spouse DOB________ Spouse SS_________________
Spouse employer: ______________________

Employment Information:

☐ Full time ☐ Part time ☐ Retired
☐ Not employed ☐_Disabled

Employer: ______________________

Occupation: ______________________

Employer Phone: ______________________

Referral Information:

Referred by: ______________________

Insurance Information:

☐ Medical Insurance ☐ Self Pay ☐ BWC

Ins Company: ______________________

Insured name: ______________________

ID number: ______________________

Emergency Contact Information:

Name: ______________ Relationship: ______________

Phone (different than yours): ______________________

Release of financial information:

I hereby authorize the release of medical information about myself to my insurance carrier(s). This information may include a report of my diagnosis, treatment, prognosis and recommendations as well as any other data deemed pertinent to consideration of my insurance claim. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted disease, psychiatric disorders, mental health diseases, drug and/or alcohol use. I am specifically authorizing the release of all health care information about myself relating to any of the above named conditions, diagnostic testing or treatment. I also hereby assign to Carl A. Minning, Jr., M.D., Ross C. Bloomberg, M.D., Chris A. Minning, M.D., and Craig J. Miller, M.D., all payments from my insurance carrier(s) for medical services I received at Eye Surgery Associates of Zanesville, Inc. I understand that I am responsible for any balance that is not covered by my insurance carrier(s).

Patient signature: ______________________ **Date:** __________

FOR PATIENTS WHO ARE MINORS:

MOTHER's Information:

First Name: ______________________ MI ____

Last Name: ______________________

Nickname: ______________________

Address: ______________________

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Home phone: ______________________

Cell phone: ______________________

Employer: ______________________

Birthdate: ______________________

Social Security: ______________________

FATHER's Information:

First Name: ______________________ MI ____

Last Name: ______________________

Nickname: ______________________

Address: ______________________

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Home phone: ______________________

Cell phone: ______________________

Employer: ______________________

Birthdate: ______________________

Social Security: ______________________