PATIENT INFORMATION

Name: ____________________ Soc. Sec.# ____________
Last Name First Name Initial

Address: ____________________ Home Phone: ____________

City: ____________ State: ______ Zip: ______ Cell Phone: ____________

Sex: M ☐ F ☐ Age: ______ Birthdate: ______ E-mail: ____________

Patient Employed by: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

Spouse's Name: ____________ Date of Birth: ____________

Family Physician: ____________ Phone: ____________

Whom may we thank for referring you? ____________ Your Optometrist: ____________

What is your reason for visit? ____________ Last exam date: ____________

Do you have difficulty hearing? Yes ___ No ___ If so, have you sought help for your hearing problem? Yes ___ No ___

Would you be interested in receiving a complimentary hearing evaluation by a certified Audiologist? Yes ___ No ___

Do you wear hearing aids? Yes ___ No ___ If so, are you satisfied with their performance? Yes ___ No ___

In case of emergency list the nearest friend or relative not living with you. Relationship: ____________

Name: ____________ Address: ____________

City: ____________ State: ______ Zip: ______ Phone: ____________

INSURANCE INFORMATION

Person responsible for the bill: ____________________
Last Name First Name Initial

Relationship to the patient: ____________ Birthdate: ______ Soc. Sec.# ____________

Address (if different from the patient's) ____________ Phone: ____________

City: ____________ State: ____________ Zip ____________

Person Responsible Employed by: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

Insurance Company: ____________________

Contact # ____________ Group # ____________ Subscriber I.D. # ____________

AUTHORIZATIONS

I, the undersigned, have insurance coverage with ____________________

And assign directly to **Dr. E. Lelis, M.D. & Associates** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____________________ ____________
Signature of Insured Guardian Date

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made either to me or on my behalf to **Dr. E. Lelis, M.D. & Associates** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If " other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance carrier.

____________________ ____________
Signature of Insured Guardian Date

PLEASE FILL OUT ADDITIONAL INFORMATION ON REVERSE SIDE

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name____ Birthdate__________________________

Signature____ Date______________________________

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr.____and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient____ Date________________________

Witness____ Date________________________