

## Patient Information Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

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

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ph.# ( ) \_\_\_\_\_ (h)  
( ) \_\_\_\_\_ (w)  
( ) \_\_\_\_\_ (c)

Occupation/Grade \_\_\_\_\_

Check one:

Employer/School \_\_\_\_\_

Single

Medical Doctor \_\_\_\_\_

Married

Divorced

Widowed

Emergency Contact Name \_\_\_\_\_ Contact Phone# \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### **Acknowledgement of Receipt of Notice of Privacy Practices for Elite Eye Care of Huntsville**

This practice is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

"I acknowledge that I have received the Notice of Privacy Practices for Elite Eye Care of Huntsville."

Name of Patient (please print): \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of patient or authorized representative Date

### Vision Insurance Information

*Vision Insurance? Y / N*

Name of Vision Insurance \_\_\_\_\_

Name of Primary Insured (if not self) \_\_\_\_\_

Name of Primary Insured Employer \_\_\_\_\_

Primary Insured's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Insured's Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

