CHARLOTTE OPHTHALMOLOGY
Center for Sight

PATIENT INFORMATION FORM

MR. / MRS. / MS. _____

Last Name: _____ First Name: _____ MI _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ / _____ / _____ / _____

Street City State Zip Code

Home Phone: (____) _____ Bus. Phone: (____) _____ Cell Phone: (____) _____

Social Security #: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

EMAIL Address: _____ Occupation: _____

(By listing your email, you are giving COC permission to send promotions, discounts, etc.)

Employer Name & Address: _____

Name, Phone No. & Relationship of someone we may contact in an emergency: _____

_____

Name of Medical Doctor: _____ Referred by: _____

Do you have Insurance, including Medicare, which may cover any part of your visit? ☐ Yes ☐ No

If Yes, Name of Insurance Co.: _____

Does your insurance require you to receive a referral from your primary care physician? ☐ Yes ☐ No

Please allow us to make copies of your insurance card(s).

If patient is not responsible for payment, please indicate who is: _____

Relationship to patient" _____ Daytime Phone # : (____) _____

Address: _____

Is your insurance coverage through **You** or your **Spouse/Guardian**? (Please circle one); if insurance is through your Spouse or Guardian, please fill out information below:

Name of Insured: _____ DOB: _____ SSN: _____

Employer: _____ Insurance Company: _____ Policy Number: _____

Does this plan cover Medical and Vision Care? ☐ Yes ☐ No

If you have separate Vision coverage, please list name of **Vision Plan:** _____

New Policy

Beginning April 1, 2013, due to changes created by the Affordable Health Care Act, there will be nominal fees charged for completing medical reports requested by patients (for example: driver's license forms, disability forms, copies of medical records, refills or prescription changes handled outside of an office visit, etc.) There will also be fees for any phone or email consults. Thank you.

Patient Signature: _____ Date: _____