*Please fill out form completely* **CATARACT & LASER INSTITUTE** **DATE: _____**

## PATIENT INFORMATION

_____ _____ _____ _____-_____-_____ _____
**Last Name** **First Name** **MI** **Date of Birth** **Age**

_____-_____-_____ ☐ ☐ ☐ ☐ ☐ ☐
**Social Security Number** **Married/Widowed/Single/Other** **Marital Status (circle one)** **Male/Female/Decline** **Gender**

_____ _____ _____ _____ (_____) _____
**Patient's Mailing Address** **City** **State** **Zip** **Cell Phone**

_____ _____ _____ _____ (_____) _____
**Patient's Physical Address** *(If different from mailing)* **City** **State** **Zip** **Home Phone**

_____
**Email Address**

## PHYSICIAN INFORMATION

_____ _____ _____ _____ (_____) _____
**Primary Care Physician** **Street Address** **City** **State** **Phone Number**

_____ _____ _____ _____ (_____) _____
**Other Physicians & Specialty** **Street Address** **City** **State** **Phone Number**

## SPOUSE'S INFORMATION

_____ _____-_____-_____ _____ (_____) _____
**Spouse's Full Name** **Date of Birth** **Age** **Phone Number**

_____ _____ _____ _____ (_____) _____
**Spouse's Employer** **City** **State** **Zip** **Work Number**

## IF PATIENT IS A MINOR

_____ _____-_____-_____ _____-_____-_____ (_____) _____
**Mother Full Name** **Social Security Number** **Date of Birth** **Cell or Home Number**

_____ _____ (_____) _____
**Home Address** *(If different from above)* **Mother's Employer** **Work Phone**

_____ _____-_____-_____ _____-_____-_____ (_____) _____
**Father Full Name** **Social Security Number** **Date of Birth** **Cell or Home Number**

_____ _____ (_____) _____
**Home Address** *(If different from above)* **Father's Employer** **Work Phone**

## PHARMACY INFORMATION

_____ _____ _____ _____ (_____) _____
**Pharmacy** **Street Address** **City** **State** **Phone Number**

## RACE AND ETHINICITY *(Please mark all that apply)*

| | | | |
|---|---|---|---|
| ☐WHITE | ☐GERMAN<br>☐ENGLISH | ☐ITALIAN<br>☐FRENCH | ☐FRENCH<br>☐POLISH |
| ☐HISPANIC,LATINO, OR SPANISH | ☐MEXICAN<br>☐CUBAN | ☐COLOMBIAN<br>☐SALVADORIAN | ☐PUERTO RICAN<br>☐DOMINICAN |
| ☐BLACK OR AFRICAN AMERICAN | ☐AFRICAN AMERICAN<br>☐NIGERIAN | ☐JAMAICAN<br>☐ETHIOPIAN | ☐HATTIAN<br>☐SOMALI |
| ☐ASIAN | ☐CHINESE<br>☐ASIAN INDIAN | ☐FILIPINO<br>☐VIETNAMESE | ☐KOREAN<br>☐JAPANESE |
| ☐OTHER: *PLEASE LIST* | | | |
| ☐DECLINE TO SPECIFY | | | |

**EMERGENCY CONTACT**

_____ _____ (_____) _____(_____) _____
**Full Name** **Relationship** **Home/Cell Phone** **Work Phone**

**AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATON:**
**I authorize my physician and/or administrative and clinical staff of Cataract & Laser Institute of So OR, PC to disclose general medical information, financial, and other protected health information to the following persons and/or entities listed below.** *If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.*
***Please list name and relationship of person(s) whom you wish to allow access***: *(e.g.: spouse, son, daughter, sibling, caretaker, or friend).*

_____ _____ (_____) _____

_____ _____ (_____) _____
**Name of Person(s) or Entity** **Relationship** **Phone Number**

**I hereby authorize Cataract & Laser Institute of So. OR, PC/Eye Surgery Center to leave detailed personal health information by the following means:** *Please Initial All That Apply*

_____ **Voicemail message on my home phone** (_____) _____
***Initial*** **Phone Number**

_____ **Voicemail message on my cell phone** (_____) _____
***Initial*** **Phone Number**

_____ **Voicemail message on my work phone** (_____) _____
***Initial*** **Phone Number**

_____ **Voicemail message at a different location** (_____) _____ _____
***Initial*** **Phone Number** **Location**

_____ **Voicemail message with my spouse/partner/friend** (_____) _____ _____
***Initial*** **Phone Number** **Name/Relationship**

_____ **Voicemail message with a relative** (_____) _____ _____
***Initial*** **Phone Number** **Name/Relationship**

**DO YOU HAVE AN "ADVANCE DIRECTIVE"?** ☐ **No** ☐ **Yes** *(Please provide a copy)*

**PATIENT EMPLOYER INFORMATION**

**Occupation Title or Retired** _____

_____ _____ _____ _____ (_____) _____
**Employer** **City** **State** **Zip** **Work Phone**

**INSURANCE INFORMATION** *(Please provide your insurance cards)*

_____ _____ _____ _____
**Primary Insurance** **Policy Number** **Group ID Number** **Subscriber**

_____-_____-_____ _____ ☐ ☐ ☐
**Date of Birth** **Employer** **Self Spouse Child** **Relationship to Subscriber** *(circle one)* _____-_____-_____ **Social Security Number**

_____ _____ _____ _____
**Secondary Insurance** **Policy Number** **Group ID Number** **Subscriber**

_____-_____-_____ _____ ☐ ☐ ☐
**Date of Birth** **Employer** **Self Spouse Child** **Relationship to Subscriber** *(circle one)* _____-_____-_____ **Social Security Number**

_____ _____ _____
**Third Insurance** (*If applicable)* **Policy Holder Name** **Policy Number**

**If Due to Injury:** **Case Number:** _____ **Workers Comp** ☐ **Auto Accident** ☐
_____-_____-_____ _____ (_____) _____
**Date of Injury** **Contact Person** **Phone Number**

I have been provided an explanation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and I understand and consent for Cataract & Laser Institute of SO OR, PC the use and disclosure of protected health information about myself for treatment, payment and health care operations. I authorize the release of any medical information necessary for processing. I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider should I wish to change one or more of the items listed above.

_____ _____
**Signature of Patient or Patient Representative** **Date**