Orangeburg Eye Center, LLC

Patients Information:

Name

Last:_____ First:_____ Middle:_____

Address:_____

Mailing Address City State Zip

Date of Birth:_____/_____/_____ **Social Security #:**_____-_____-_____

Month Day Year

Cell Phone:_____ **Home Phone:**_____

Primary Care Physician: _____

EMAIL: _____

Emergency Contact:

Name:_____Phone:_____Relationship:_____

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Responsible Party Information:

Name:_____

Relationship to Patient:_____

Phone Number:_____

Social Security Number:_____-_____-_____

Date of Birth:_____/_____/_____

Address:_____

Mailing Address City State Zip

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Name of person(s) to whom we may discuss your healthcare and/or your bill:

Name:_____Relationship to you:_____Phone:_____

Name:_____Relationship to you:_____Phone:_____

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Check all that apply:

( )Single ( )Married ( )Widow(er) ( )Separated ( )Divorced

( )Hispanic/Latino ( )African American ( )White ( )Native American

( )Asian/Pacific ( )Other

( )Male ( )Female Preferred Language:_____

Patient's Employer:_____

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Authorization: I authorize payment of Medicare, BCBS, Medicaid or other insurance benefits be made directly to OEC on my behalf for treatment rendered to me by one of its physicians. I also authorize OEC to disclose my personal health information to any entity requiring this information for the purpose of treatment, payment and healthcare operations.

Patient Signature:_____Date:_____

Responsible Party Signature:_____ Date:_____