Midshore Surgical Eye Center
PATIENT INFORMATION SHEET

PATIENT NAME: _____

MARITAL STATUS: _____ **RACE:**_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL:** _____

MAILING ADDRESS:_____ STATE: _____ **ZIP:** _____

DATE OF BIRTH: _____ **S.S. #:** _____

EMERGENCY CONTACT PERSON: _____ **PHONE#** _____

PRIMARY M.D.:_____ **EMPLOYER:** _____

REFERRING DR: _____

PRIMARY INS: _____ VISION: yes / no

SECONDARY INS:_____VISION: yes / no

POLICY HOLDER: _____PATIENT / SPOUSE / PARENT

POLICY HOLDER'S DATE OF BIRTH:_____

Is this illness/injury the result of an Automobile or Work Accident? yes / no
If YES, please provide billing info
_____

PLEASE LIST ANY PERSON THAT YOU GIVE PERMISSION TO CALL ON YOUR BEHALF TO DISCUSS YOUR MEDICAL CARE OR FINANCIAL ACCOUNT:

_____ Name / Relationship

_____ Name / Relationship

_____ Name / Relationship

_____ Name / Relationship

PRIVACY NOTICE:
By signing below I acknowledge receipt and review of The Privacy Notice and give permission for JAMES P THOMPSON, MD PA to call and/or leave messages on the phone numbers provided above.

FINANCIAL RESPONSIBILITY:
I am responsible for obtaining any pre-authorization or referral needed to this office as required by my insurance carrier. I will be responsible for any balance not covered by my insurance carrier(s) and for full balance of visit if proper insurance information is not presented to this office timely.

X_____ _____