HESTER OPHTHALMOLOGY

PATIENT INFORMATION Social Security # _____

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: M F Marital Status: S M W

Race/Ethnicity: ☐Caucasian ☐African American ☐Asian ☐Hispanic/Latino ☐Other Language: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail address: _____ Preferred Contact: ☐Home ☐Cell ☐Email

Employer: _____ Phone: _____

Spouse Name: _____ Spouse DOB: _____

Phone: Spouse Cell: _____ Spouse Work: _____

If liability - Date of injury: _____ ☐ Work-related ☐ Motor Vehicle ☐ Other

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RESPONSIBLE PARTY INFORMATION (if other than patient)

☐ Spouse (information listed above) OR ☐ Another Person:

Name: Last _____ First _____ MI _____

Date of Birth: _____ Relationship to patient: _____

Address: *(If different than above)* _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____ Work: _____

EMERGENCY CONTACT

☐ Spouse (information listed above) *OR* Another Person:

Name: _____ Relationship : _____

Phone: Home: _____ Cell: _____ Work: _____

How did you learn about Hester Ophthalmology? ☐ I have been a patient of Dr. Hester in the past.

☐Referred by Doctor (name) _____

☐ Recommendation by friend/family member (name) _____

☐ Internet search: ☐ Our website ☐ Google ☐ Yelp ☐ Facebook ☐Other _____

I hereby authorize payments of medical and surgical benefits to Hester Ophthalmology, PC as applicable. I understand that I am financially responsible for any charge whether or not paid by my insurance. I understand that some services, including refractions, are not covered by some insurance plans or by Medicare and that I am responsible for payment at the time those services are rendered. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Hester Ophthalmology, PC as applicable. I authorize the release of any information required to process any and all claims for reimbursement on my behalf or to treat my condition. I understand that co-payments are due at the time of service.

Patient Signature: _____ Date: _____

Please bring your insurance card(s) and co-pay with you to your appointment.