Patient Name_____ Today's Date_____/_____/_____

Title Mr. Ms. Mrs. Miss Dr. Other_____ Suffix Sr. Jr. III Other_____

Address: _____
(Street) (City) (State) (Zip)

Sex: M / F Date of Birth_____/_____/_____ Social Security Number_____

Preferred Language:_____ Race:_____ Ethnicity: Hispanic or Not Hispanic

Phone: Home_____ Work_____ Cell_____

Email_____@_____ . _____

Complete this section only if the patient is not financially responsible:

Guarantor: _____ *Address:* _____

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

*Email*_____ *Guarantor Birthdate:*_____/_____/_____

*Guarantor Employer:*_____

Patient's Marital Status: [ ] Married If so, spouse's full name _____

[ ] Single [ ] Divorced [ ] Widowed [ ] Separated

Insurance Recipients: I authorize the release of any medical or other information necessary to process my insurance claims. I also accept request of government benefits either to myself or to the party who accepts assignment, further authorizing payment of medical benefits to VisualEyes and Dr. G Chad Green.

Primary Insurance :_____ Insured Date of Birth_____/_____/_____

Insured Name (Printed):_____

Secondary Insurance:_____ Insured Date of Birth_____/_____/_____

Insured Name (Printed):_____

Insured Signature:_____ Date_____/_____/_____

HIPPA ACKNOWLEDGEMENT

My signature below confirms that I have been provided with a copy of the Notice of Privacy Practices (NPP) of VisualEyes and have been offered a copy of such policy to keep for my records.

HIPPA Signature: _____ Date_____/_____/_____