Patient Information / Update Sheet

Elliott Vision Care

Name First | M.I. | Last | "Nickname"

Address | City | State | Zip

Home Phone # | ***Mobile #*** | ***Work #*** | ***<--Please Circle Preferred Contact***

Date of Birth | ***Age*** | ***Sex*** | ***Social Security #*** | ***Marital Status*** | ***Primary Care Doctor***

/ / | | M F | | |

Occupation / Student? | ***Spouse / Parent Name*** | ***Spouse/Parent Employer***

Employer | Address | City | Zip | Phone

Emergency Contact | Relationship | Phone

Account Responsible Party (Circle) **Patient's Relationship:** Self Spouse Child Other

(If "Self" is responsible, then no need to complete responsible party information)

Name First | M.I. | Last

Address | City | State | Zip

Home Phone # | ***Mobile #*** | ***Work #*** | ***<--Please Circle Preferred Contact***

Date of Birth | ***Sex*** | ***Social Security #*** | ***Marital Status*** | ***Employer***

/ / | M F | | |

Medical / Insurance Information

Dr. Jeff Elliott is a provider for the following insurance plans; please ***circle*** your insurance(s), and provided a copy of ***all*** your insurance cards, if available:

Medicare	Eyemed	Blue Cross / Blue Shield
Medicaid (Soonercare)	OSMA	Champus / Tricare
Vision Service Plan (VSP)	HealthChoice	Coast to Coast

If we will be filing a claim on your insurance, please completely fill out all insurance info forms. Incomplete information will result in the insurance not paying on the claim, and you will be responsible for payment.

Authorization / Signature on File

I authorize Dr. Jeff Elliott to perform an eye exam and/or render appropriate treatment upon myself or my minor child.

I certify that I have read & understand all the information to the best of my knowledge & understand that providing incorrect information can be dangerous to my health.

I authorize Dr. Jeff Elliott to release any information including the diagnosis & the records of any treatment or exam rendered to myself or my child during the period of such eye care to third party payers &/or health practitioners.

I authorize & request my insurance company to pay directly to Dr. Jeff Elliott.

***Regardless of insurance coverage, I understand that I am responsible for payment of this account & agree to pay according to the policies of Dr. Jeff Elliott of Elliott Vision Care.*

- I also acknowledge that I received a copy of Elliott Vision Care's Office Policies and Notice of Privacy Practices.

X |

Signature of Patient (or Parent if a Minor) ***Date***

Rev 5/1/2009