# PATIENT INFORMATION SHEET

**Office of Cord R. Linville, O.D. & David E. Scott, O.D.**

Patient Acct. #_______ (12/27/2023)

Legal Name (First)________________________________ (Last)____________________________ (Middle Initial) _____

Nick Name____________________________________ Gender ______M ______F Date of Birth_____/_____/_______
(at birth)

Address (Street)________________________________(City)___________________(State)___________(Zip)__________

Telephone (Home)______________________ (Work)________________________ (Cell)__________________________

E-Mail________________________________________ I prefer to be contacted at ___Hm ___Wk___Cell ___E-mail
(check one)

Social Security#______________________ Spouse's Name____________________________ Phone_______________

Marital Status ________________________ Language _______________________ Race ________________________

Ethnicity: Not Hispanic or Latino ______ Hispanic or Latino ____ __Unknown _____ Patient declined to answer ______

Occupation_______________________________ Place of Employment________________________________________

Employment Address________________________________________________________________________________

Emergency Contact Person ____________________________________Telephone______________________________

**Release of Medical Information**

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): ____________________________________________ Relationship to Patient: __________________________

Primary Medical Doctor's Name____________________________ Address____________________________________

Doctor's Telephone__________________ Referred By____________________________________________________

**RESPONSIBLE PERSON FOR PAYMENT** (If same as above, write the word 'Same').

Name (Last) _________________________(First) ____________________ (Initial) _____ Relationship______________

Address (Street) _________________________(City)_____________________(State)_______(Zip)___________________

Telephone (Home)________________________ (Work)________________________ (Cell)______________________

Date of Birth____/____/_______ Place of Employment_______________________________________________

**PAYMENT POLICY:** All fees are due at the time services and/or materials are provided. If Family Eye Health Center, LLC is a provider for your insurance, we will file your insurance. Any balance remaining after the insurance is finalized payment is due at that time.

**I authorize the release of any medical or other information necessary to process my insurance claims. I understand that any balance after my insurance has paid is my responsibility.**

__________________________ ______________________________________________________

**(Date)** **(Patient's or Responsible Person's Signature)**

**Please have your vision and medical insurance cards available for the receptionist to scan.**