Baptist Eye Surgeons, PLLC

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❑ Mark Ivens, M.D.
❑ Charles H. Lindsey, M.D.
❑ J. Franklin Murchison, M.D.
❑ Paul B. Pruett, M.D.
❑ Darin S. Smith, M.D.

PATIENT INFORMATION

ACCOUNT NUMBER_____ DATE_____ UPDATE_____

LAST NAME_____ FIRST_____ MI_____

MAILING ADDRESS _____

EMAIL ADDRESS _____CELL #_____

CITY_____ STATE_____ ZIP_____ PHONE_____

EMPLOYER_____ EMPLOYER PHONE_____

SEX_____ MARITAL STATUS_____ BIRTHDATE_____

SOCIAL SECURITY NUMBER_____

PHARMACY NAME: _____ PHONE #: _____

DO YOU HAVE: LIVING WILL ☐ YES ☐ NO POWER OF ATTORNEY ☐ YES ☐ NO

SOME EYE DISEASES ARE MORE PREVALENT IN CERTAIN RACES AND/OR ETHNIC GROUPS. WHILE THIS INFORMATION IS OPTIONAL, PROVIDING THIS INFORMATION MAY HELP YOUR PHYSICIAN PROVIDE BETTER EYE CARE.

RACE: ☐ ASIAN ☐ BLACK ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER _____

PRIMARY LANGUAGE _____

SPOUSE/GUARDIAN INFORMATION

SPOUSE/GUARDIAN NAME_____ SPOUSE/GUARDIAN SS#_____

SPOUSE/GUARDIAN EMPLOYER_____ EMPLOYER PHONE_____

SPOUSE/GUARDIAN DATE OF BIRTH_____

PERSON OR NEAREST RELATIVE TO CONTACT IN CASE OF EMERGENCY_____

_____ PHONE NUMBER_____

DID SOMEONE SEND YOU TO US?_____ WHO?_____

IF NOT, HOW DID YOU HEAR ABOUT US?_____

FAMILY PHYSICIAN_____ PHONE NUMBER_____

FAMILY PHYSICIAN ADDRESS_____

OVER

I am financially responsible to pay Baptist Eye Surgeons, PLLC for services the doctors and ancillary personnel provide. Payment in full is due at the time service is rendered.

If I am a Health Plan enrollee, I will be responsible for paying all charges the insurance plan does not allow, such as non-covered services (Refractions), deductibles, co-insurance, and co-payment amounts. I will make these payments at the time of service. If the insurance claim is rejected, I will be responsible for paying the entire amount, depending on the plan's contractual obligations.

_____

Patient Signature

_____

Date

RELEASE OF INFORMATION AND INSURANCE BENEFIT AUTHORIZATION

I hereby authorize and direct Baptist Eye Surgeons, PLLC, when and as requested, to disclose any or all of the information in my medical records needed to determine benefits or the benefits for related services to any person such as any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf. This assignment will remain in effect until revoked by me in writing. I further authorize the Baptist Eye Surgeons, PLLC to disclose such information to its insurance carrier or carriers when so requested by the carrier.

I also authorize and direct the named insurer to pay directly to the Baptist Eye Surgeons, PLLC any or all benefits up to the amount of my bill accruing to me in connection to my treatment. For Medicare/Medicaid recipients: I certify that the information given by me for payment under title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

_____

Patient Signature

_____

Date