PATIENT INFORMATION SHEET (PLEASE PRINT & FILL OUT COMPLETELY)

(MR, MRS, MS, DR) LAST NAME: _____ FIRST NAME: _____ MI: ____

SUFFIX: _____ (Sr., Jr. III, etc.) PREFERRED NAME: _____ D.O.B: _____/_____/_____

SSN#:_____ MARITAL STATUS: □M □S □D □Other MALE □ FEMALE □

LANGUAGE: _____ RACE: _____ **ETHNICITY**: □ Hispanic or Latino □ **NOT** Hispanic or Latino

Preferred Number □ HOME (_____) _____ OK TO LEAVE MESSAGE □

Preferred Number □ CELL (_____) _____ OK TO LEAVE MESSAGE □

(May we leave messages/detailed medical information on voicemail at either of these phone numbers?)

E-MAIL_____ OK TO LEAVE MESSAGE □

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

****

EMPLOYED □ YES □ NO YOUR EMPLOYER: _____POSITION:_____

PRIMARY CARE PHYSICIAN: _____ REFFERED BY:_____

PHYSICIAN PHONE (____)_____ **PHYSICIAN FAX** (_____)_____

PERSON RESPONSIBLE FOR BILL: _____ PHONE (_____) _____

EMERGENCY CONTACT NAME: _____ PHONE (_____) _____

****

INSURANCE INFORMATION

PRIMARY (MEDICAL) INSURANCE: DO YOU REQUIRE A REFERRAL? □ YES □ NO □ DON'T KNOW

(PRIMARY) INSURANCE PLAN NAME: _____
PERSON WHO CARRIES PLAN: □ SELF □ SPOUSE □ PARENT □ OTHER

NAME OF PERSON WHO CARRIES PLAN: _____

DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY# _____

SECONDARY INSURANCE:

INSURANCE PLAN NAME: _____
PERSON WHO CARRIES PLAN: □ SELF □ SPOUSE □ PARENT □ OTHER

NAME OF PERSON WHO CARRIES PLAN: _____

DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY# _____

VISION INSURANCE PLAN

INSURANCE PLAN NAME: _____
PERSON WHO CARRIES PLAN: □ SELF □ SPOUSE □ PARENT □ OTHER

NAME OF PERSON WHO CARRIES PLAN: _____

DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY # _____

Tucker & Associates Eye Care
9875 Medlock Bridge Parkway, Suite 100
Alpharetta, Ga 30022

REQUEST FOR PHARMACY INFORMATION

This is for all Commercial, Vision and Medicare patients. We are now participating in E-Scribing, in compliance with the new Medicare Guidelines and for the convenience of our patients. We ask that you fill out the information below, so should we need to provide you with a prescription, we will be able to E-Scribe directly to the Pharmacy of your choice.

We will be sending all prescriptions through at the end of the business day. This policy also applies for all refill requests by phone or in person. Thank you for providing our office this information so we can continue to provide you with excellent care.

Patient Name:_____

Patient Date of birth:_____

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Phone:_____

Pharmacy Address:_____

Pharmacy City, State, Zip: _____

TUCKER & ASSOCIATES EYE CARE AND LASER CENTER

MEDICAL CENTER OPTICIANS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have read a copy of
(Print Name of Patient)
Tucker & Associates Eye Care and Laser Center's Notice of Privacy Practices.

_____ _____
Signature of Patient Date
(Parent if patient is a minor)

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____