



CINCINNATI EYE INSTITUTE

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Account # _____

Patient Information Sheet

Mr. Mrs. Ms. Patient Name: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____ - _____

Home Phone: () _____ Work Phone: () _____

Cellular Phone: () _____ Gender: M F Birth Date: _____

Social Security Number: _____ Marital Status: S M D W Sep

Employer: _____ Email Address: _____

Emergency Contact Information

Contact Name: _____ Phone: () _____ Relation: _____

Contact Name: _____ Phone: () _____ Relation: _____

Miscellaneous Information

Family Physician: _____ Phone: () _____

Ophthalmologist/Optomtrist: _____ Phone: () _____

Who suggested you come to CEI?: _____ Phone: () _____

Patient Insurance Information

Primary Insurance: _____ Insured Name: _____

Insured Phone: () _____ Relation: _____ Birth Date: _____

Insured Employer: _____ Insured SS#: _____

ID #: _____ Group/Policy #: _____ Co-pay \$ _____

Secondary Insurance: _____ Insured Name: _____

Insured Phone: () _____ Relation: _____ Birth Date: _____

Insured Employer: _____ Insured SS#: _____

ID #: _____ Group/Policy #: _____ Co-pay \$ _____

I request the insurance carrier or Medicare to pay directly to Cincinnati Eye Institute the amount due for any services rendered. I also agree to pay any amount that the insurance carrier or Medicare deems as not a covered benefit and also any amount the insurance carrier or Medicare determines to be my responsibility. I agree to treatment deemed necessary by the physician and authorize the release of any medical information required by the involved parties to be necessary to process this claim. I acknowledge I have read and agree to Cincinnati Eye Institute's Financial Policy. I acknowledge that I have received a copy of version 1 of Cincinnati Eye Institute's Notice of Privacy Practices with an effective date of April 14, 2003.

Signature of patient/patient representative _____ Relationship _____ Date _____