

**LUDWICK EYE CENTER
PATIENT INFORMATION FORM**

Patient's Name _____ Age _____ Date of Birth _____
(First) (Middle Initial) (Last)

(If guarantor other than patient, please fill out the additional information on reverse)

Sex _____ M _____ F Race: _____

P.O. Box _____ Married _____ Single _____ Divorced _____ Widowed _____
(IF YOU HAVE A P.O. BOX WE NEED TO HAVE A PHYSICAL ADDRESS)

Physical Address _____

City: _____ State _____ Zip Code _____

Home Phone: () _____ SS #: _____ - _____ - _____

Cell Phone: () _____ Email: _____ @ _____

Employer _____ Address: _____

Work Phone: () _____ Occupation: _____

Spouse's Name: _____ Date of Birth _____ SS# _____

Address: (if different than patient's) _____

_____ City _____ State _____ Zip Code _____

Phone Number (if different than patient's)

Home: () _____ Work: () _____ Employer: _____

Cell #: () _____ Email address _____ @ _____

In case of emergency, contact (other than spouse) _____

Address: _____ City: _____ ST _____ Zip _____

Relationship: _____ Phone: () _____

Authorization – PLEASE READ BEFORE SIGNING

To process my medical claims for payment, I, _____, hereby authorize Ludwick Eye Center or their authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf. I understand that these records and/or information may include information regarding HIV, psychiatric/psychotherapy, mental health and or drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize Ludwick Eye Center to release copies of my medical records to include the above-mentioned records and/or information to my primary care, family or other treating physicians and optometrists.

I understand that if this is a workers' compensation claim the insurance carrier may employ a rehabilitation or consulting firm to handle my case. I authorize release of the above-mentioned records and/or information to the workers' compensation insurance carrier and/or the rehabilitation or consulting firm.

I hereby assign to Ludwick Eye Center all payments for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance carrier are my financial responsibility.

Signature of patient/parent/legal representative: _____ Date: _____

(OVER)

MEDICAL INSURANCE INFORMATION
 (Please allow us to make a copy of your insurance card)

Insurance Company	Policy #	Group #	Policyholder or Subscriber	Policyholder's Date of Birth
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. Vision Insurance _____				
a. We DO NOT participate with many vision plans.				

Referral Information: (Please tell us how you were referred to our practice)

Family Physician: _____
 Address: _____ Phone Number: _____
 Optometrist: _____
 Address: _____ Phone Number: _____

Whom may we thank for your referral?
 Lecture _____ Screening _____ Advertisement _____ Friend _____ Family _____
 Optician _____ Optometrist _____ Telephone Directory _____ Doctor _____
 Name of referring person/doctor _____

**ADDITIONAL INFORMATION
 IF PATIENT IS A CHILD OR MINOR**

Child's Mother: _____ Date of Birth _____
 Address _____ City _____ State _____ Zip Code _____
 Home # () _____ Cell # () _____ Work # () _____
 Mother's Employer _____
 Address _____ City _____ State _____ Zip Code _____

Child's Father: _____ Date of Birth _____
 Address _____ City _____ State _____ Zip Code _____
 Home # () _____ Cell # () _____ Work # () _____
 Father's Employer _____
 Address _____ City _____ State _____ Zip Code _____

Are parents married? _____ Yes _____ No Are parents separated? _____ Yes _____ No
 Who is financially responsible for this child? _____
 Relationship: _____ Address (if different than parents) _____
 City _____ State _____ Zip _____ Phone # () _____

INSURANCE INFORMATION: (If different than information from above)

Who is the insurance coverage through, mother or father or both? _____
 Which is primary? _____
 Mother's insurance _____ ID# _____
 Father's insurance _____ ID# _____