GRIFFIN EYE
CENTER

843-449-6414

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill in or Correct All Fields)

Patient's Name_____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____Other/Phone_____

☐ **By checking this box you are giving us your permission to send messages to your email, cell phone or physical address.** Driver's License # _____ State Issued _____

Age _____ Birthdate _____ SS# _____ Sex____

Marital Status ☐Single ☐Married to: _____☐Other: _____

Race: _____ Ethnicity: _____ Language:_____

Patient's Employer_____Occupation_____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐Yes ☐No

Address_____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient_____

Home Phone _____ Work Phone _____ Other Phone _____

Address_____
Street & Suite # City State Zip

Primary Health Insurance Company_____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required?☐ No ☐ Yes Copay? ☐ No ☐ Yes, $_____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐No☐Yes Copay?☐ No☐Yes, $_____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Griffin Eye Center to file my claims etc. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Griffin Eye Center and myself.

Signature _____ **Date** _____