***** PLEASE GIVE DRIVERS LICENSE, OR IDENTIFICATION CARD, AND ALL INSURANCE CARDS TO RECEPTIONIST *****

PLEASE COMPLETE ALL 4 PAGES (BEING 2 PAGES FRONT & BACK)

- PATIENT INFORMATION -

Last Name:	First:	MI:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Preferred Name:	Home Phone:	Cell Phone:	Birth Date:	Age:	Sex: ☐ M ☐ F

Mailing Address:	Social Security #:	Preferred *Method* of Contact: CELL HOME PH EMAIL WORK

City:	State:	Zip Code:	Email:

Occupation:	Employer:	Work Phone:

Who may we thank for referring you to our office?	☐ Friend:	☐ Dr.		☐ Sign

☐ Website	☐ Newspaper	☐ Insurance List	☐ Yellow Pages	☐Other:

Other ***IMMEDIATE*** family members seen in our office:

- PATIENTS INSURANCE INFORMATION -

Primary Insurance:	Subscriber's Name:	Subscribers DOB:	Subscribers SS#:	Policy or ID#:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Subscriber's Employer:

Secondary Insurance (if applicable):	Subscriber's Name:	Policy or ID#:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Subscriber's Employer:

*** EMERGENCY CONTACT ***

Name of local friend or relative for Emergency Contact:	Relationship to patient:	Home phone:	Work phone:

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not SMEC.

****** Insurance may not cover Contact Lens Evaluations and/or fittings; in this case, the patient accepts full responsibility for payment in full for these services at time of visit. ******

Some visits may have specialist co-pay. I hereby authorize payment of benefits billed to my insurance to SMEC. I hereby accept responsibility for payment for any service provided to me that is not covered by my insurance, or for fees that exceed the payment made by my insurance. If SMEC does not participate with my insurance, I accept responsibility in full for any services rendered or product purchased. I agree to pay all co-payments, co-insurance, and deductibles at the time the service is rendered.

***** Patient/Guarantor/Parent or Guardian(if under 18) Signature ***** **Date**

PLEASE CONTINUE TO THE NEXT PAGE

*** HIPAA ACKNOWLEDGMENTS ***

* ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE *

I acknowledge that I was given access to, offered, and/or received a copy of, Dr. Coy A. Brown, O.D.'s Notice of Privacy Practices.

Patient name ____

Signature ____ Date __________________

* APPOINTMENT REMINDERS & MESSAGE PERMISSIONS *

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

Signature ____ Date _______________________

* RELEASE OF PRIVILEDGED MEDICAL INFORMATION PERMISSIONS *

In keep with the Notice of Privacy Act, HIPAA regulations, we are unable to discuss your health care, personal information, or disclose information necessary for your continuum of care with any individual not listed in the Notice of Privacy Act. If you wish for Smoky Mountain Eye Care to be able to discuss or disclose information with certain individuals (not being insurance agencies), please list below the people whom you authorize Smoky Mountain Eye Care to share medical information with. (For example, daughter, mother, sister, friend, etc.)

Name	Relationship	Phone#

***** Patient Signature ***** **Date**

PLEASE CONTINUE TO THE NEXTPAGE