

Last Name:	First Name:		MI:
Date of Birth:	Social Security #:_		
Marital Status: ☐ Single ☐ Married ☐ ☐	Divorced Widowed	<u>Gender:</u> □ Ma	ale □ Femal
Race: African American American	Indian □ Asian □ Cauca	asian	\square Other
Ethnicity: Hispanic Non-Hispanic	Preferred Language:	English □ Spanish □ C	Other:
Smoker: ☐ Yes ☐ No	Height: ft	in <u>Weight:</u>	lbs
Local Address:			
City:	State:	Zip Code:	
Home Phone: ()	Employer:		
Cell Phone: ()	Occupation	n:	
Work Phone: ()	Email:		
Emergency Contact:	PH:	Relationship:	
Preferred Method of Co	ommunication: Home P	hone Cell Phone Er	mail
Primary Care Physician:			
Address:			
Pharmacy Name:			
Address:			
Referring Physician:			
Address:	Pl	none:	
How did you hear about Twin Forks Op	tometry? Google	Newspaper Website	☐ Insurance
☐ Relative/Friend/Patient Name:			
☐ Professional Referral:			

Medical Insurance Information Primary Insurance: Member ID: Subscriber's Name: Subscriber's DOB: Patient relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:______ Insured SSN:_____ Subscriber's Address (if different from patient): Secondary Insurance: _____ Member ID: _____ Subscriber's Name: _____ Subscriber's DOB: _____ Patient relationship to Insured: Self Spouse Child Other: Insured SSN: Subscriber's Address (if different from patient): Accident Insurance Information Date of Injury/Accident:_____ Workers Compensation Insurance Carrier: Insurance Carrier Address: Phone: WCB Case #: _____ Carrier Case #: _____ Contact Person: _____ Employer when Injury Occurred: Phone: Employer Address:____ On the date of the injury what was your job title/description: What were your usual work activities: No Fault Insurance Carrier: Claim #: Insurance Carrier Address: _____ Contact Person: Phone: _____ School Accident Insurance Carrier: Claim #: Insurance Carrier Address: Phone: Phone: School District: **Insurance Authorization & Release HIPAA & ABN** I understand that my insurance carrier will not pay for some items or services. I agree to be personally and fully responsible for the payment at the time services are rendered. If my insurance carrier denies coverage for any reason, I am responsible for payment. I understand that it is not the responsibility of Twin Forks Optometry, PLLC to know my personal plan coverage. It is my responsibility as the covered member to know the details of my insurance plan. I certify that the information provided is true and correct. Signature of Patient or Guardian Date