Last Name:_____ First Name:_____ MI:___

Date of Birth:_____ Social Security #:_____

Marital Status: □ Single □ Married □ Divorced □ Widowed Gender: □ Male □ Female

Race: □ African American □ American Indian □ Asian □ Caucasian □ Pacific Islander □ Other

Ethnicity: □ Hispanic □ Non-Hispanic Preferred Language: □ English □ Spanish □ Other:_____

Smoker: □ Yes □ No Height: _____ ft _____ in Weight: _____ lbs

Local Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Employer: _____

Cell Phone: (_____)_____ Occupation: _____

Work Phone: (_____)_____ Email: _____

Emergency Contact: _____ PH: _____ Relationship: _____

Preferred Method of Communication: Home Phone Cell Phone Email

Primary Care Physician:_____

Address:_____ Phone:_____

Pharmacy Name:_____

Address:_____ Phone:_____

Referring Physician:_____

Address:_____ Phone:_____

How did you hear about Twin Forks Optometry? □ Google □ Newspaper □ Website □ Insurance

□ Relative/Friend/Patient Name:_____

□ Professional Referral:_____ □ Other:_____

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:_____

School District:_____ Phone:_____

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