PATIENT INFORMATION

Date_____

Name _____ Social Security No. _____

Street Address_____City_____State _____Zip Code _____

Home Phone _____ Cell Phone _____ E-Mail_____

Preferred Methods of Contact: ❑ Text Message ❑ E-Mail ❑ Phone Call (please choose preferred number) ❑ Home ❑ Cell ❑ Work

❑ Male ❑ Female Date of Birth_____ Age_____ ❑ Single ❑ Married ❑ Widowed ❑ Other _____

Race/Ethnicity: ❑ White/Caucasian ❑ Black or African American ❑ Asian ❑ Hispanic or Latino ❑ Other _____

Referred by: ❑ Internet Search ❑ Social Media ❑ Friend/Family Member _____ ❑ Other _____

Reason for your Visit _____

Patient Employer _____ Occupation _____

Business Address_____ Business Phone_____

Emergency Contact Name _____Relationship_____ Phone No._____

INSURANCE INFORMATION

Policy Holder Name _____ Relationship to Patient_____

Date of Birth _____ Social Security # _____ Policy Holder Employer _____

Address (If different than patient) _____

Medical Insurance Company _____ ID# _____Group#_____

Vision Insurance Company _____ ID# (if applicable) _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to all providers of the medical benefits, if any; otherwise payable to me for services rendered by Dr. Jared Powelson or Dr. Michael Gerstner. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any costs incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for payment to Dr. Jared Powelson or Dr. Michael Gerstner for all services rendered to the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Patient or Guardian Signature _____Date_____

RELEASE OF MEDICAL RECORDS AND INFORMATION

To: Custodian of Medical Records

This authorizes you to release to Midtown Eye Care, 16 N. McLean Blvd, Memphis, TN 38104, full and complete medical records, reports, evaluations, consultations or information (collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all of the conditions recited herein.

The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless Midtown Eye Care, including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Patient or Guardian Signature _____Date_____

ACKNOWLEDGEMENT OF PRIVACY POLICY

I acknowledge that I have viewed and been offered a copy of the privacy policy for Midtown Eye Care.

Patient or Guardian Signature _____Date_____