

Albemarle Eye Center, PLLC

Patient Intake Form

Patient's Name: _____
Last First Middle

Street Address: _____

City/State/Zip: _____

Social Security Number: _____ Date of Birth: _____ Sex: M F

Home Phone: __ (____) _____ Work Phone: _ (____) _____

Cell Phone: __ (____) _____ E-Mail: _____

Emergency Contact: _____ Phone: _ (____) _____

Patient's Employer: _____ Phone: _ (____) _____

Full Address: _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Race: _____ Ethnicity: _____

How do you prefer we contact you: ___ Phone ___ Mail ___ E-Mail

Referred by: ___ Friend/Relative ___ Telephone Book ___ Advertisement ___ Speaking Engagement ___ Other

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary Coverage _____ Policy # _____

Secondary Coverage _____ Policy # _____

Office Policies

- You are responsible for the entire balance on your account at the time service is rendered unless we have a special contractual relationship with your insurance company. Please discuss this with us in advance to avoid misunderstandings.
- We expect full payment for co-payments and deductibles at the time services are rendered
- We cannot bill insurance for cosmetic or non-covered services. Full payment must be made at time of service.
- If you need to cancel an appointment, we request 24 hour advanced notification. Failure to cancel may result in a charge.

Signature states an understanding of the above information and authorization for the physician to examine and treat this patient as well as authorizes AEC to release medical information to your insurance company. Further, perform diagnostic testing and provide treatment for the patient named above.

Signature of Patient

Signature of Guardian (if under 18)