

Douglas L. Huff, O.D.

PATIENT INFORMATION*MEDICAL HISTORY

Thank you for choosing our office for your eye care needs. It is our objective to give you the best possible eye care in a friendly professional manner. In order to serve you properly, please complete the following information. All information is held confidentially.

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cell Phone or Work Phone# _____
 Male Female Date of Birth _____ Social Security Number _____
Check appropriate box Single Married Divorced Widowed Other _____
 Employed Homemaker Student Retired Other _____
Employer _____ Business Address _____
Spouse's Name _____ Employer _____
If a student, name of school/college _____
Person to call in case of emergency _____ Phone _____
Referred by: Co-worker Friend Relative Name _____
 Insurances Yellow Pages Other _____
Method of payment: Credit Card Cash Check Other _____

Responsible Party

Person responsible for account _____ Relationship to Patient _____
Address if different _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Employer _____ Is this person a patient in this office Yes No

Insurance Information (Please provide copy of card)

This information pertains to the person who carries the insurance.

Name of insured _____ Relationship to Patient _____
Date of Birth _____ Social Security Number _____ Work Phone _____
Name of employer _____ Insurance Company _____
Address of Insurance _____ City _____ State _____ Zip _____
Group Number _____ If there is Separate Vision Insurance who is carrier _____

Do you have additional or secondary insurance? Yes No

Who is it with? _____ (Please provide copy of card)

Authorization and Release

I hereby authorize the doctor and /or staff of this office to administer such drugs and perform diagnostic and therapeutic procedures as may be necessary in the course of my examination. The information which appears on this history is correct to the best of my knowledge.

I also authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I hereby authorize payment of insurance benefits to be paid directly to the doctor. I understand that if my insurance does not pay for these services, I am responsible for all cost incurred and will pay for these charges.

Patient/Guardian Signature: _____ Date: _____