

Carolina Eye Center
3227-C Sunset Blvd.
West Columbia, SC 29169
Phone: 803-794-0000 Fax: 803-794-0003

Chart# _____

Today's Date: _____

We request that you complete this form each year. Thank you for helping to keep your record accurate:

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SS#: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Insurance change: yes no

Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Primary: _____ Secondary: _____

EMERGENCY CONTACT (relative/friend NOT residing with you):

Name: _____ Phone: _____

LIFETIME AUTHORIZATION

I authorize reports of my evaluation, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that I have or will identify to you. I authorize any holder of medical or other information about me, to release to the Social Security Administration and The Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if this is a Workmen's Compensation claim, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all costs of collection agency fees, attorney fees and court costs, if any.

GUARANTOR SIGNATURE: _____ **DATE** _____

Person responsible for payment of account

CAROLINA EYE CENTER

3227-C Sunset Boulevard
West Columbia, SC 29169
803-794-0000

www.carolinaevecenters.com
www.facebook.com/carolinaevecenter

Name: (please print) _____ Date: _____

E-mail: (please print) _____

**Yes! I would like for you to email me information about the following:
(please check all that apply)**

Eye Conditions:

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blepharoplasty |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Glaucoma Laser Treatments |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> LASIK Surgery |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Muscle Relaxing Injections |
| <input type="checkbox"/> Conjunctivitis (Pink Eye) | <input type="checkbox"/> Refractive Lens Exchange |
| <input type="checkbox"/> Blepharitis | |
| <input type="checkbox"/> Retinal Detachment | |
| <input type="checkbox"/> Pinguecula | |
| <input type="checkbox"/> Strabismus (Lazy Eye) | |
| <input type="checkbox"/> Styte | |
| <input type="checkbox"/> Vitreous Detachment | |
| <input type="checkbox"/> Vitreous Floaters | |
| <input type="checkbox"/> Astigmatism | |
| <input type="checkbox"/> Hyperopia (Farsightedness) | |
| <input type="checkbox"/> Myopia (Nearsightedness) | |
| <input type="checkbox"/> Presbyopia | |

Lenses & Frames:

- | |
|--|
| <input type="checkbox"/> Anti-Reflective Treatment |
| <input type="checkbox"/> Computer Lens Overview |
| <input type="checkbox"/> Frames Selection Overview |
| <input type="checkbox"/> High-Index Lenses |
| <input type="checkbox"/> Polarized Lenses |
| <input type="checkbox"/> Polycarbonate Lenses |
| <input type="checkbox"/> Progressive Lenses |
| <input type="checkbox"/> Sunglasses Overview |
| <input type="checkbox"/> Variable Tinted Lenses |

Contact Lenses:

- | |
|---|
| <input type="checkbox"/> Contact Lens Compliance |
| <input type="checkbox"/> Contact Lens Care, Insertion/Removal |
| <input type="checkbox"/> Monovision Overview |

Patient Signature: _____