Memorial Hospital
725 Glenwood Drive, Ste. 892
Chattanooga, TN 37404
Telephone: (423)624-3937
Fax: (423)629-6505

Eyecare Associates, P.C.

4511 Hixson Pike
Hixson, TN 37343
Telephone: (423)870-3742
Fax: (423)877-9494

DATE:_____

PATIENT NAME

Last: _____
First: _____MI: _____
Address: _____
City: _____ST: _____Zip: _____
Home: _____Cell: _____
Date of Birth: _____SS#_____
Gender: _____M _____F
Email: _____

NAME OF SPOUSE/GUARANTOR

Last: _____
First: _____MI: _____
Employer Name: _____
Employer Phone: _____
Cell: _____
Date of Birth: _____
Relationship to pt: _____

PCP/Family Dr _____

Race:

___American Indian/Alaska native ___Black/African American ___Asian ___White
___Native Hawaiian/other pacific island ___Hispanic ___Other ___Refused to report

Ethnicity: _____Hispanic/Latin _____Non Hispanic _____Refused to report
Language: ____English ____Spanish ____French ____Japanese ____Chinese ____Other

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

PHARMACY

Name: _____Location/City: _____
Prescription Insurance: _____
Mail Order Pharmacy: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder: _____
Policy ID _____ Policy Holder DOB _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder: _____
Policy ID _____ Policy Holder DOB _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

I authorize payment of medical benefits to Eyecare Associates, PC, for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify that the information contained herein is correct. I will be responsible for the full payment amount of the charges. I agree to pay any collection fees if legal action is necessary in the collection effort of this account.

X _____

Signature of Patient or Guarantor if Patient is a Minor