Chart No._____

Oculofacial & Plastic Surgery
CONSULTANTS

Patient Information

All bolded materials must be completed by patient

***First Name:** _____ MI:____ ***Last Name:**_____

***Sex:**_____ ***Date of Birth:**_____

***Address:**_____

***City:**_____ ***State:**____ ***Zip:**_____

***Phone (Home):**_____ ***Phone (Cell):**_____

***Contact Preference: Home ☐ Cell ☐** Permission to call: Yes ☐ No ☐

Permission to text: Yes ☐ No ☐

***Email Address:**_____

I would like to receive emails about special offers: Yes ☐ No ☐

Primary Insurance:**_____Secondary Insurance:** _____

***<u>Emergency Contact 1</u>**

***Name**: _____ ***Phone**: _____ (home/cell)

***Relation to Patient:** _____

<u>Emergency Contact 2</u>

Name: _____ Phone: _____ (home/cell)

Relation to Patient: _____

OPSC may reach out to the Emergency Contact(s) listed above regarding

☐ **All Healthcare, Scheduling, and Payment Information**

☐ **Only Scheduling and Payment Information**

☐ **Only for purposes of contacting me, once all direct patient contact avenues have been exhausted**

Chart No._____

For Medicare reporting purposes we ask that you fill out the demographic information below:

Patient's preferred language: _____

Patient's race: _____

Patient's ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Patient's marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

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How did you learn about our services?

- ❏ Doctor Referral
  - ❏ Name of Doctor: _____
- ❏ Friend or Relative
  - ❏ Name of Friend/Relative: _____
- ❏ Newspaper or Magazine
  - ❏ Name of Newspaper/Magazine: _____
- ❏ Our Website

By signing this authorization below I acknowledge the following:

- The information I have provided above is correct and most current to the best of my knowledge
- That failure to notify Oculofacial & Plastic Surgery Consultants (OPSC) of any changes to my contact information and insurance(s) in a timely-manner may result in a delayment of treatment and/or additional out-of-pocket costs due to the time-sensitive manner of insurance authorizations for treatments and procedures.

* _____ _____

Patient Signature Date

* _____ _____

Witness Signature Date