NEVADA EYE PHYSICIANS

YEARLY DEMOGRAPHICS FORM

Patient Information

Patient's First Name:	Middle Name:	Last Name:	
Patient's Address:	City:	State:	Zip:
Gender:	Marital Status:	Date of Birth (Age):	Social Security Number:
Home Phone:	Mobile Phone:	Email Address:	
Referred by:	Primary Care Physician:	Primary Care Physician Phone:	
Pharmacy Name:	Pharmacy Phone:	Pharmacy Address:	

How did you hear about us?_____

Employer/ School:	Occupation:	Employer/School Phone:	
Employer/ School Address:	City:	State:	Zip Code:

Emergency Contact Information

Emergency Contact Name:	Emergency Contact Phone:	Relation to Patient:

Insurance Information

Primary:_____	Secondary:_____
ID/Group:_____	ID/Group:_____

Policy Holder:_____D.O.B._____ Policy Holder:_____D.O.B._____

PROTECTED HEALTH INFORMATION AUTHORIZATION

Please allow access to my Protected Health Information (PHI) (all medical data and information) to:

_____	_____	_____
Person's name /company	Relationship	Phone Number

ACKNOWLEDGEMENT/ CONSENT

I hereby acknowledge that I have been that I have been presented this Notice of Privacy Practices and this consent acknowledges and permits Nevada Eye and Ear to use and disclose personal health information to carry out treatment, payment, or healthcare operations.

Signature:_____ Date:_____D.O.B._____

Signature of personnel representative:_____

SIGNATURE ON FILE

I hereby authorize payment of my medical and surgical benefits to Nevada Eye and Ear. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments, co-insurance, and deductibles are designated by my insurance company or health plan; I agree to pay them to Nevada Eye and Ear. I authorize Nevada Eye and Ear to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Signature:_____ Printed Name of Person Signing:_____Date:_____