Tennessee River Eye Clinic ***Patient Information***

Name: _____ Birth Date: _____SS#: _____

Sex: M [ ] F [ ] Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Race: No response [ ] Black/African American [ ] White [ ]

Native American/Alaskan [ ] Asian/South Asian [ ] Hawaiian/Pac Islander: [ ]

Preferred Language: English [ ] Spanish [ ] Other:_____

Ethnicity: No response [ ] Hispanic [ ] Non-hispanic [ ]

Street Address: _____

City: _____State: ___ Zip:_____ Home phone: ( )_____

Cell: ( )_____ Work/other: ( )_____ email:_____

Preferred Contact: Home [ ] Work [ ] Cell [ ] Text cell [ ]

Employer: _____ Phone: ( ) _____

Address: _____

Spouse's Name: _____ Birth Date: _____ SS#: _____

Employer:_____ Phone: ( )_____

Cell: ( )_____ Work/other: ( )_____ email: _____

Responsible Party Information **[ ] Same as patient**

Name:_____ Birth Date: _____ SS#: _____

Sex: M [ ] F [ ]

City: _____State:_____ Zip:_____ Home phone: ( )_____

Cell: ( )_____ Work/other: ( )_____ email:_____

Preferred Contact: Home [ ] Cell [ ] Work [ ] Text cell [ ]

Employer: _____ _____ Phone: ( )_____

Address: _____

Insurance Informative **(We will copy your insurance card.)**

Insurance Company Primary: _____ Policy #:_____

Secondary: _____ Policy#: _____

Emergency Contact **[ ] Same as Spouse**

Name: _____ Relationship: _____

Phone: Home ( )_____ Cell ( )_____ Work ( )_____

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Mark A Kassels MD/Tennessee River Eye Clinic of all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay the full bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all costs of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection.

Patient/Responsible Party Signature: _____ Date: _____