Northern Ohio Eye Center, Inc.

Mr Mrs Miss Ms ____ Male _____ Female_____

Address________________________________ City ______________ State ______ Zip __________

Email Address ______________________________ Date of Birth ______________ Age __________

Home Phone (______) - ________ - ________________ Cell Phone (______) - _________ - __________________

Employer Name ______________________________ Employer Phone (______) - _______ - ________________

Social Security # _________ - __________ -___________ Marital Status: Single Married Divorced Widowed

EMERGENCY CONTACT: ______________________________**PHONE** (______) - _______ - ________________

Policy Holder who is financially responsible for insurance: _____ Self _____ Spouse or _____ Other

If Spouse or other, Name ____Date of Birth _______________

Relationship to patient: ______________________________________

Primary Insurance ____________________________ Secondary Insurance ____________________________

PREFERRED PHARMACY ____

Street ____ City ____________________________

Who is your family doctor? ____

Who has provided your most recent eye exam? ____

How did you hear about us? _______ Optometrist _______ Family Doctor _______ Screening ______ Newspaper

Relative ____ Friend ______________________________________

According to the **HIPAA POLICY** I give permission for you to discuss my medical condition with the following person(s):

This could be Spouse, Relative or other ____

I hereby assign, transfer, and set over to Northern Ohio Eye Center, Inc., all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine those benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I have been offered or received a copy of the Northern Ohio Eye Center's Notice of Privacy Policies.

DISCLOSURE OF FINANCIAL INTEREST: Stanley F. Pajka, M.D. has a financial interest in Northern Ohio Eye Center, Inc., which in turn has a financial interest in Vision Surgery Center, LLC.

SIGNATURE: ____ **DATE** ________________________