International Eye Center
4506 Wishart Place, Tampa, Florida 33603 813-875-6588 Fax: 813:873-3688

PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Today's Date _____

PATIENT'S NAME (First, Middle, Last)	PATIENT'S DOB	PATIENT'S AGE
PATIENT'S MAILING ADDRESS (City, State)	ZIP CODE	PATIENT'S SEX
PATIENT'S HOME PHONE NUMBER (Area Code, Number)	PATIENT'S SOCIAL SECURITY NUMBER	
WHO CAN WE THANK FOR THIS REFERRAL?	PATIENT'S PEDIATRICIAN OR FAMILY DOCTOR & PHONE NUMBER	
NAME AND RELATIONSHIP OF FAMILY MEMBERS SEEN HERE		
PATIENT'S EMAIL ADDRESS		

PATIENT'S EMPLOYER	SPOUSE'S NAME
PATIENT'S WORK PHONE (Area Code, Number, Ext.) FAX NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER
1ST INSURANCE - POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
2ND INSURANCE - POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
EMERGENCY CONTACT	
PATIENT'S CELL NUMBER	

FOR MINORS:

MOTHER'S NAME (Legal Guardian)		FATHER'S NAME	
MOTHER'S EMPLOYER		FATHER'S EMPLOYER	
WORK PHONE (Area Code Number, Ext.)	FAX NUMBER	WORK PHONE (Area Code Number, Ext.)	FAX NUMBER
MOTHER'S SOCIAL SECURITY NUMBER		FATHER'S SOCIAL SECURITY NUMBER	
NAME(S) OF PATIENT'S SIBLINGS (Name & Age, Name & Age, Name & Age) CHILDREN ONLY			

PAYMENT AUTHORIZATION

I understand that payment of all medical care is due and payable at the time of service, and that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any cost incurred in the collection of patient's account in case of default, including reasonable attorney fees, court costs, and thereby waive presentment for payment, protection, and notice of protection, and non-payment of outstanding account. I understand it is my responsibility to provide current and accurate insurance information to file claims.

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to the undersigned physician or supplier.

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SIGNATURE DATE

AUTHORIZATION TO ADMINISTER DIAGNOSTIC OPHTHALMIC DROPS

I consent to the administration of diagnostic ophthalmic drops by the medical personnel of the International Eye Center (Perez and Perez, M.D.'s, P.A.) during the course of the examination. I understand that these dilating drops are an essential part of the ophthalmic examination and may produce sensitivity to light and slightly blurred vision lasting from four (4) to twenty-four (24) hours.

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AUTHORIZED SIGNATURE PATIENT RELATIONSHIP