Stokes Regional Eye Centers
Sumter Eye Center

ALL PATIENTS MUST BE AT LEAST 18 YEARS OF AGE OR ACCOMPANIED BY AN ADULT

PATIENT #

PATIENT NAME (FIRST, MIDDLE, LAST)	OCCUPATION	RACE/ETHNICITY

SEX M F	AGE	DATE OF BIRTH	MARITAL STATUS S / M / W / D / SEP	SOCIAL SECURITY NUMBER	E-MAIL ADDRESS

PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	HOME PHONE#
MAILING ADDRESS (IF DIFFERENT THAN STREET ADDRESS)	**CELL PHONE#**
PATIENT: EMPLOYER NAME AND ADDRESS	**WORK PHONE#**

LOCAL PHARMACY NAME AND LOCATION	MAIL ORDER PHARMACY NAME

FAMILY PHYSICIAN NAME AND ADDRESS

PRIMARY INSURANCE PROVIDER		POLICY HOLDER NAME
DATE OF BIRTH	SOCIAL SECURITY #	EMPLOYER NAME
SECONDARY INSURANCE PROVIDER		POLICY HOLDER NAME
DATE OF BIRTH	SOCIAL SECURITY #	EMPLOYER
TERTIARY INSURANCE PROVIDER		POLICY HOLDER NAME
DATE OF BIRTH	SOCIAL SECURITY #	EMPLOYER
EMERGENCY CONTACT		RELATIONSHIP

HOME PHONE #	CELL PHONE #	WORK PHONE #

I HEREBY AUTHORIZE TREATMENT OF MYSELF OR THE MINOR DESCRIBED ABOVE. I AUTHORIZE NECESSARY DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND SREC HEALTH CARE OPERATIONS (TO INCLUDE BILLING OF MY INSURANCE COMPANY AND ELECTRONICALLY PRESCRIBED MEDICATION UNLESS INDICATED). I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

DATE _____

PATIENT/PARENT OR GUARDIAN SIGNATURE _____

***FOR MINOR CHILDREN WE NEED THE NAME AND SOCIAL SECURITY NUMBER OF **BOTH** PARENTS FOR THE PURPOSE OF MEDICAL RECORD REQUESTS AND IN CASE OF EMERGENCY.

NAME OF MOTHER	SS# DOB
NAME OF FATHER	**SS# DOB**