Jeffries Eye Clinic, P.A.
P.O. Box 7094
Springdale, AR 72766

Please read carefully and fill out all spaces completely

PATIENT INFORMATION

LAST NAME: __________________________FIRST NAME:__________________________MIDDLE INITIAL_____
MAIDEN NAME_______________________________SOCIAL SECURITY #: ______________________ SEX: M F
BIRTHDATE: _________________________ HOME PHONE #: ____
DAYTIME PHONE#________________________EMAIL ADDRESS____
SPOUSE OR PARENT'S NAME____
ADDRESS: _____________________________ CITY__________________ STATE ___________ ZIP_______________
MARRIED/ DIVORCED/ WIDOWED/ SINGLE FULLTIME STUDENT : YES / NO AGE______________
VETERAN: YES / NO SMOKER: YES / NO RACE____
LANGUAGE SPOKEN____

EMPLOYER INFORMATION

CURRENTLY EMPLOYED? YES / NO_________ WORK PHONE #: _____________________
EMPLOYER NAME____
ADDRESS__________________________________CITY___________________STATE AND ZIP_________________

INSURANCE INFORMATION IF MORE SPACE NEEDED-PLEASE PLACE SECONDARY ON BACK

(IF WE MAY TAKE A COPY OF YOUR INSURANCE CARD, PLEASE DO NOT FILL OUT THIS SECTION)

INSURANCE COMPANY NAME: ____PLAN #_________________________
GROUP NAME____GROUP NUMBER____________________________
POLICY NUMBER____
ADDRESS: _____________________________________CITY, STATE & ZIP:__________________________________
_______________________________PHONE #: __________________ POLICY #: ________________________________
INSURANCE CO-PAY:________ EFFECTIVE DATE_____________________EXPIRE DATE___________________

INSURED NAME: __________________________ RELATION TO PATIENT: _______________

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT: ____________________________ PHONE #: __________________________STREET
ADDRESS___________________________________CITY__________________________STATE & ZIP_____________

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS & CONSENT FOR EXAMINATION

I HEREBY AUTHORIZE JEFFRIES EYE CLINIC, P.A. TO GIVE MY INSURANCE COMPANY, MY ATTORNEY OR MY PHYSICIAN ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I HEREBY ASSIGN TO THE CLINIC ALL PAYMENTS FOR MEDICAL SERVICES, SHOULD IT DESIRE TO TAKE SUCH ASSIGNMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I FURTHER AUTHORIZE DR. JEFFRIES AND THE STAFF OF JEFFRIES EYE CLINIC, P.A. TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

____ ___________________________________
SIGNATURE OF PARENT/GUARDIAN DATE

____ ___________________________________
SIGNATURE OF PATIENT DATE