PLEASE PRINT

Holicki Eye Centers and Holicki Optical
Patient Information

PLEASE PRINT

First Name: ____________________

Last Name: ____________________

Address: ____________________

City: ________ State ____ Zip ________

Date of Birth: _____/_____/________

Social Security # _____/_____/______

Home Phone: ( ) ______________

Cell Phone: ( ) ______________

E-Mail: ____________________

Gender: Male or Female

Marital Status: Single Married Widowed Divorced

Emergency Contact: ______________

Relationship: ______________

Phone: ( ) __________

Primary Care Doctor: ______________

Phone: ( ) __________

Fax: ( ) __________

Pharmacy Name: ______________

City: ______________

Phone: ( ) __________

Occupation: ____________________ Employer: ______________| Retired

Work Phone: ( ) __________ Work Fax: ( ) __________

CARD HOLDER OR RESPONSIBLE PARTY, IF OTHER THAN PATIENT

Name: ____________________ Social Security #: ____/___/____ Date of Birth ___/___/____

Relationship to Patient: ______________ Employer: ____________________

Address: ____________________ Address: ____________________

City ________ State ___ Zip _____ City ________ State ___ Zip _____

Home Phone ( ) ______________ Work Phone ( ) ______________

Occasionally, on your behalf and with your permission, it is necessary for us to disclose or share your Protected Health Information with another person/s. Please specify the individual/s and what protected health information can be shared

None: ☐Do not share my protected health information with anyone other than myself

Name: ____________________ Relationship: ______________

What can be shared: ☐All Health Information | ☐Specific information to be shared: ______________

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I have received a copy of Holicki Eye Centers Payment Policies. These policies authorize the following: Paying benefits to providers, release of information for my treatments, release of prescriptions for eyewear or medications, information needed to process my claims, payment policies for services rendered or for items that are ordered, No-Show fees, Returned Check fees and Patient Privacy Practices. I was also offered a copy of the Notice Of Privacy Practices.

By signing below, I am stating that I have read, understand & were offered a copy of the payment policies of Holicki Eye Centers & Optical & understand that this form & my signature will remain in effect while I am under the care of Holicki Eye Centers & Optical.

Signed (Patient or responsible Party)____________________ Date ___/__/___