

# Liberty Ophthalmology

27 Clairedan Drive

Powell, OH 43065

614-841-9300

Date \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Nickname \_\_\_\_\_

**Birthdate** \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

OK to leave message with detailed information?

Landline \_\_\_\_\_

OK to leave message with detailed information?

Email \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Spouse/Parent/Guardian \_\_\_\_\_

### IF DIFFERENT FROM ABOVE:

Insurance Subscriber \_\_\_\_\_

Birthdate \_\_\_\_\_

SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Referred by \_\_\_\_\_

### For office use only

Insurance \_\_\_\_\_

Co-Pay \_\_\_\_\_

Date \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_

Send report to:

\_\_\_\_\_  
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Office Notes

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Reviewed \_\_\_\_\_ Reviewed \_\_\_\_\_ Reviewed \_\_\_\_\_

## ACKNOWLEDGEMENT

1. I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Eric W. Lothes, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Eric W. Lothes, MD may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed and all claims have been submitted and paid.

Signature\_\_\_\_\_ Date\_\_\_\_\_

2. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature\_\_\_\_\_ Date\_\_\_\_\_

3. I have received the Notice of Financial Policies and I have been provided an opportunity to review it.

Signature\_\_\_\_\_ Date\_\_\_\_\_