# THE EYE CLINIC

*Farshid Paydar, MD*

Board Certified Ophthalmologist

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## PATIENT INFORMATION

PATIENT NAME_________________________________ SPOUSE NAME___________________________________

EMAIL: ______________________________________________________ By giving us your email address you are consenting to being registered on our patient portal

PATIENT BIRTHDATE_______________________________________ PATIENT GENDER (Circle One) Male Female

PATIENT SOCIAL SECURITY #____________________________ HOME PHONE_____________________________

ADDRESS_______________________________________ CITY_________________ ST______ ZIP_______________

EMPLOYER_______________________________________ BUSINESS PHONE_______________________________

GUARANTOR NAME___________________________________ RELATIONSHIP_____________________________

WHO REFERRED YOU? ______________________________ PRIMARY CARE DOCTOR_______________________

CURRENT MEDICATIONS____________________________________________________________________

_______________________________________________________________________________________

DRUG ALLERGIES__________________________________________________________________________

PRIMARY INSURANCE__________________________________ SECONDARY_____________________________

INSURED NAME____________________________________________________________________________

INSURED SOCIAL SECURITY #___________________________ INSURED BIRTHDATE_______________________

DO YOU SMOKE? Y N DO YOU DRINK? Y N DO YOU USE RECREATIONAL DRUGS? Y N

HAVE YOU OR DO YOU HAVE

HEART TROUBLE: Y N DIABETES: Y N

HIGH BLOOD PRESSURE: Y N THYROID: Y N

BEEN DIAGNOSED WITH HIV: Y N GLAUCOMA: Y N

**Authorization to Pay Benefits to Physician:** I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services such as co-pay, deductibles and fees not a benefit of my insurance plan.

**Authorization to Release Information:** I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

**X**_____________________________________________________________________________________

**Signature (Patient or Parent if minor)** **Date**


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