Southland Eye Associates, PC
19950 S Governors Hwy
Olympia Fields, IL 60461
708-481-4600
www.southlandeye.com

Patient Information

Name: MR. MRS. MISS MS.	FIRST	MIDDLE	LAST	Today's Date:

Home Phone:		Social Security #: - -	
Work Phone:		Birth Date: / /	Age:
Cell / Pager / Other:		Gender: M F	Marital Status: Single Divorced Married Widowed
E-Mail:			
Address:	Apt.	Occupation:	
City:	State: Zip:	Employer:	
Emergency Contact:		Special Needs: ☐ Hearing-impaired ☐ Wheelchair ☐ Walker ☐ Other: _____ ☐ Translator Language: _____	
Phone:			
Relationship to patient:			
PRIMARY Insurance:		***Patient is the policy subscriber / guarantor:*** ☐ Yes ☐ No	
ID / Policy #:			
SECONDARY Insurance:		☐ Yes ☐ No	
ID / Policy #:			
VISION / OPTICAL Insurance:		☐ Yes ☐ No	
If policy subscriber / guarantor is other than the patient:			
Name:		Social Security #: - -	
Phone:		Birth Date: / /	
Relationship to patient:		Employer:	
Family / Primary Physician:		Phone:	
Address:			
Pharmacy:		Phone:	
Address:			

- I acknowledge receipt of the "Summary of Privacy Practices" (rev. September 23, 2013) and understand that I may request to review the full-length "Notice of Privacy Practices" (rev. September 2013). _____ (initial)

- I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician. If my insurance denies the claims, I agree to be financially responsible for my bill, and I have read and understand the "Statement of Patient Financial Responsibility" provided to me. _____ (initial)

Patient Signature: _____ **Date:** _____