



Patricia W. Smith, M.D.
Franklin T. Li, M.D.

PATIENT INFORMATION

Name _____ Tel _____ Male/Female Preferred Language _____
 First MI Last
Address _____ City _____ State: _____ Zip _____
Social Security # _____ D.O.B. ____/____/____ Age _____ Marital Status _____ Race _____ Ethnicity _____
E-Mail Address _____ How did you hear about us? _____
Primary Care Physician _____ Referring Physician _____
Emergency Contact Name _____ Tel _____ Relationship _____
Employer _____ Address _____ Tel _____

INSURANCE

Pharmacy Preference: _____

Name of Primary Insurance _____ Name of Secondary Insurance _____

Relationship to Patient: Self Spouse Parent Other Spouse/Parent Name: _____

Do you need a referral? Yes No Do you have a co-payment? No Yes \$ _____ Deductible: Yes No \$ _____

CERTIFICATION OF INFORMATION

I certify that the identifying information, addresses, and telephone information I have provided is correct and agree to inform the practice if such information changes or becomes outdated.

Printed Name or Power of Attorney

Patient's Signature or Power of Attorney

Date

AUTHORIZATION TO RELEASE PATIENT RECORDS TO INSURER

I hereby authorize Triangle Eye Physicians, P.A. to release any and all of my records to my insurer, or any other third party payor, legally responsible for the payment of medical expenses for care provided, as is required by North Carolina Insurance Regulations. I understand that this authorization allows Triangle Eye Physicians, P.A. to release to my insurer or financial payor any information concerning me, including but not limited to confidential information, financial records, and the records of any treatment or examination rendered me. I understand that this release, and any future general release that I may sign, specifically allows for the release of information to my insurer or financial payor concerning HIV test results and/or related data that may be a part of my medical records. This general release and authorization shall remain in effect until revoked by me in writing.

Printed Name or Power of Attorney

Patient's Signature or Power of Attorney

Date

ASSIGNMENT OF BENEFITS

To: Third-Party Payor/Insurance Carrier/Supplemental Insurance In consideration of service rendered by Patricia Smith, M.D., Franklin Li, M.D, their agents and staff, I hereby assign to Triangle Eye Physicians, P.A. the benefits due to me under my health insurance plan. I agree that I shall be responsible for all portions of payments due to Triangle Eye Physicians, P.A. for services received that are not covered by the above such as annual deductible, co-payments, and co-insurance. I agree that I shall be solely responsible for the entire bill for services or any balance thereof that may be determined to be not covered by my health plan. This assignment of benefits shall remain in effect, even if my insurance carrier changes, until revoked in writing.

Printed Name or Power of Attorney

Patient's Signature or Power of Attorney

Date