Dr. Jackie L. Schwartz
Independent Doctor of Optometry at World Eyeglasses

PATIENT INFORMATION SHEET

GENERAL INFORMATION

First, Last, MI, Preferred Name:

Street Address:

City, State, Zip:

Phone, Type:

Phone 2, Type:

Email:

Preferred Contact Method: ◯ *cell phone* ◯ *email* ◯ *text* ◯ *other (please explain)*

Patient Social Security Number:

Date of Birth:

Male/Female:

Occupation/Employer: ◯ *full-time* ◯ *part-time*

Marital Status: ◯ *married* ◯ *single* ◯ *divorced* ◯ *legally separated* ◯ *widowed*

Language, Race, Ethnicity:

Emergency Contact Person and Phone:

INSURANCE INFORMATION

Vision Insurance:

Vision Insurance Member Name:

Vision Insurance Member ID#:

Vision Insurance Member Date of Birth:

I certify that I have received a copy of Notice of Privacy Practices, the Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Dr. Jackie L. Schwartz's health care operations. The Notice of Privacy Practices also describes my rights and Dr. Jackie L. Schwartz's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of Dr. Jackie L. Schwartz at World Eyeglasses at 6215 N, Federal Hwy. Fort Lauderdale, FL 33308. I request that payment of authorized medicare, medicaid or other insurance benefits to be made to me or on my behalf to Dr. Jackie L. Schwartz for any services furnished. I authorize any holder of medical information about me to release to health care financing administration and its agents, any information needed to determine these benefits payable for related services.

PATIENT SIGNATURE _____

How did you learn about our office?
◯ Radio ◯ Flyer ◯ Internet ◯ Yellow Pages ◯ Previous Patient
◯ Walk by ◯ Doctor ◯ Television ◯ Newspaper ◯ Insurance Company

◯ Referred by another patient/doctor. What was the patient's/doctor's name?_____