# Michigan Cornea Consultants
# Patient Information Sheet

Today's Date: _______________

**General:** Referring Doctor: _________________________

Patient Name: ___________________________________________ Birth Date: _________ Age: _________

Address: ___________________________________ City: _______________ State: ______ Zip: ___________

Telephone # (Home): _________________________ Social Security #: ___________________ ____________

Driver's License #: _______________________________ Sex: M F Marital Status: S M D W

Name of parent (if minor) or person to contact in an emergency: ____________________________________

Contact phone number: ____________________________________

Place of Employment: __________________________________________ Phone #: _____________________

Occupation: __________________________________________

Family Doctor (Internist or Pediatrician, if a child):

Doctor's Name: ______________________________________________ Telephone #: __________________

Address: ___________________________________ City: _______________ State: ______ Zip: __________

**Insurance:**
Who is your insurance through? Self _______ Spouse _______ Other _______________________________

IF OTHER THAN SELF: Name: ______________________________ Relationship: _______________

DOB: __________________ Social Security #: ______________________

Medicare #: _____________________________________ Medicaid #: _________________________________

Blue Shield Information: Cardholder Name: ____________________________________

Contract #: __________________________________ Group: ________________

Name of Other Insurance: ________________________________ Contract #: __________________________

Group #: _______________ Address of Insurance Co: _____________________________________________

Is this Worker's Compensation? Yes _____No _____ Date of Injury: _______________________________

Auto Accident? Yes _____ No _____ Date of Accident: __________ Insurance Co: _____________________

Claim Number: __________________ Contact Person: __________________ Telephone #: ______________

I authorize the release of any medical information necessary to process claims and authorize payment of claims to Michigan Cornea Consultants from my health insurance company. I understand that I am financially responsible for this charge or any unpaid balance.

Patient (Parent, if a minor) Signature: ______________________________________ Date: ______________