MINNESOTA OPHTHALMIC
PLASTIC SURGERY SPECIALISTS
6405 France Avenue South Suite W460 | Edina, MN 55435

PATIENT INFORMATION

3/16

Patient Name :_____ Date of Birth: _____ / ____ / _____
Last First M.I.

Address: _____
Street City State Zip

Social Security No._____-_____-_____ Sex: M F Marital Status: Married_____ Single____ Other_____

Occupation:_____Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Carrier:_____ Email: _____

How would you like your Appointment Reminder received by: Text Message: _____ Email: _____Phone: _____

Language Preferred: _____ Ethnicity: ____Hispanic or Latino ___Not Hispanic or Latino

Race: ____ American Indian/Alaska Native ___ Asian ___ African–American ___White
____ Native Hawaiian or other Pacific Islander Some Other Race: _____

Referring Physician: _____
Name Address

Primary Physician: _____
Name Address

Emergency Contact: _____
Name Phone

Do you have an Advance Directive for: CPR ____ Resuscitation ___ Life Support ___ None: ___ Other:_____

Patient or Caregiver Signature:_____ Date:_____

INSURANCE

Primary Insurance Company:_____ Policy Holder Name:_____

Date of Birth ____/____/_____ I.D. Number: _____Group Number:_____

If the patient is a minor, or if the primary policy holder is not the patient, list the guarantor of the account:
*Name:*_____ *Relationship to Patient:*_____ *Date of Birth:* ___/___/____

Secondary Insurance Company:_____ Policy Holder Name:_____

Date of Birth ____/___/_____ I.D. Number: _____ Group Number:_____

Insurance Authorization:

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurance, and other health care plans to the provider's name above. I authorize the provider name above to release any information or expenses requested by my insurance company for the express purpose of providing claims.

Patient Signature:_____Date:_____