



ELBA M. PACHECO, M.D., LLC

PATIENT INFORMATION SHEET

PLEASE PRINT

DATE: \_\_\_\_\_

How did you select our Practice:  Dr. \_\_\_\_\_,  Friend/Relative,  Insurance Listing,  Yellow Pages,  Hospital,  Newspaper (specify) \_\_\_\_\_,  Other (specify) \_\_\_\_\_

PERSONAL INFORMATION:

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

Address \_\_\_\_\_ Sex - M F

Phone# Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

May we contact you (pls. circle all that apply) Home / Work / Cell / Email Marital Status: S M Sep W D SS# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Primary Physician \_\_\_\_\_  
Name Address Telephone#

Referring Physician \_\_\_\_\_  
(if other than primary) Name Address Telephone#

INSURANCE INFORMATION: Please bring your insurance card(s) at the time of your appointment.

Primary Insurance \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient \_\_\_\_\_

Policy# \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient \_\_\_\_\_

Policy# \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

PATIENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I, the undersigned, realize that I am financially responsible for all services rendered to me by Elba M. Pacheco, M.D., LLC.

For those insurances for which Dr. Pacheco accept assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

I authorize Elba M. Pacheco, M.D., LLC to release to my insurance carrier(s) any medical information necessary to obtain reimbursement.

I permit a copy of this authorization to be used in place of the original.

I understand that it is the standard of care for Dr. Pacheco and Center for Eye and Laser Surgery (the Practice) to take patient photographs prior to and following the initiation of most clinical treatments and/or the performance of any surgical procedure on patients of the Practice.

I hereby do \_\_\_/do not \_\_\_ give my permission for the Practice to use only photographs taken of me by the Practice for physician or patient education or promotional purposes. Although the photographs will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Signature of Patient /Legal Guardian

Date