Starkville Eye Clinic
1085 Stark Rd Suite C
Starkville, Ms 39759
662.320.6636

Please Complete **ALL** blanks-Place "N/A" (not applicable) if information does not apply. **It is imperative that the information is thorough and accurate as the information is used for claims processing.**

Patient's Info

Last: First: M.I.:	Marital Status: S M W D Sex: M F
SSN# DOB:____/____/____	Ethnicity: Hispanic or Non-Hispanic Race:
Address :	Cell Phone:
Address Cont:	Home Phone:
City: State: zip:	Email:
Emergency Contact name:	Primary Care Provider (PCP):
Em. Contact Phone: ( )	PCP Phone Number:

RESPONSIBLE PARTY INFORMATION (if different than above)

Name:	Relationship to patient:
SSN#: DOB:____/____/_____	Phone #:
St. Address:	City: State: zip:

Primary Medical Insurance (The subscriber is the **person** who carries the insurance)

Insurance name:	Policy #:
Subscriber name:	Group #:
Subscriber SSN:	Relationship to insured:

Secondary Medical Insurance (The subscriber is the **person** who carries the insur-

Insurance name:	Policy #:
Subscriber name:	Group #:
Subscriber SSN:	Relationship to insured:

Vision Insurance (The subscriber is the **person** who carries the insurance)

Insurance name:	Policy#:
Subscriber name:	Group:
Subscriber SSN:	Relationship to insured:

Additional Patient information

Hobbies:	Occupation/School:
Who referred you:	Employer phone #
Spouse name: DOB:___/___/___	Employment: Full-time Part-time Not employ. Student

My signature on this page signifies that all the above information is current and accurate.

_____ _____
Patient, Guardian , or Person Representative Date