MISSISSIPPI EYE ASSOCIATES

James D. Sutton, M.D.
CATARACT & LENS IMPLANT

Debra LaPrad, M.D.
COMPREHENSIVE OPHTHALMOLOGIST

PATIENT INFORMATION FORM

Today's Date: ___/____/____ Sex: ___ M ___ F Chart#: ________________

Name: ____ DOB: ___/___/___ Age: _____SS#:___________
Last First MI

Address: ____
Street (or Location) City State Zip Code

Home Phone: (____)_____-_____ Cell: (____) ______ -_______ Alternate Phone #: (_____) ______-______

Mailing Address: ____
Street (or Location) City State Zip

Employer's Name: ________________________________ Employer's Address: ___________________________

City: ___________________________________ State: ________ Zip Code: ___________________

Marital Status: ____Single ____ Married ____ Divorced _____Widowed _____Separated
Please list the nearest relative (not living with you) ___________________________ Phone#: (____) ____-_____

GUARANTOR INFORMATION

Responsible Party's Name: ____________________________________ Relationship to Patient: _____________
DOB: _____/_____/______ Sex: ____M ____F SS#:________________________________
Address: ____
Street (or Location) City State Zip Code
Employer's Name: ____________________________________ Address: ________________________________

INSURANCE INFORMATION

Primary: Name of Insurance Company: ____
Insured Name: ____________________________ Insured DOB: ___/____/____ SS#:______________
Policy #: ______________________ Group #: ________________ Relation to Patient:____________

Secondary: Name of Insurance Company:____
Insured Name: ____________________________ Insured DOB: ___/____/____ SS#:____________
Policy #: ______________________ Group #: ________________ Relation to Patient:___________

I hereby authorize Mississippi Eye Associates to complete the proper process of medical reimbursement from my insurance carrier (as assigned under my insurance policy). By signing this form, I also give the Physician(s) of Mississippi Eye Associates authorization to treatment me.

____ _____/_____/______
Signature of Patient or Parent / Guardian **Date**