Center for Eye & Laser Surgery ADORO medical spa

ELBA M. PACHECO, M.D., LLC

PATIENT INFORMATION SHEET

PLEASE PRINT **DATE: _____**

Who can we thank for referring you to us? ☐ **Dr.** ☐ **Friend/Relative** ☐ **Advertisement** ☐**Social Media** ☐ **Website** ☐ **Other**

Please specify _____

PERSONAL INFORMATION:

Patient's Name _____ Date of Birth ____/____/_____
First MI Last

Address _____City_____Zip Code_____ 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 O 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 _____
Name Address Telephone#

Pharmacy _____City_____Phone #_____

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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# _____

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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 **D a t e**