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**PATIENT INFORMATION**

PLEASE PRINT

Patient Name \_\_\_\_\_ Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_  
 (Last) (First) (Middle)

Address \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 (Street) (City) (State) (Zip)

Birth-date: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
 (Month) (Day) (Year)  Married  Separated  
 Single  Divorced  Widowed

How did you hear of us? MD / Family / Friend / Yellow Pages / Other \_\_\_\_\_ Referring Dr. \_\_\_\_\_

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

Employer Address \_\_\_\_\_  
 (Street) (City) (State) (Zip)

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Telephone: \_\_\_\_\_

In Emergency Contact \_\_\_\_\_  
 (Name) (Telephone) (Relationship)

**RESPONSIBLE PARTY**

Name \_\_\_\_\_  Self  Parent  Other \_\_\_\_\_

Address \_\_\_\_\_ Home Tel. \_\_\_\_\_ Bus. Tel. \_\_\_\_\_  
 (Street) (City) (State) (Zip)

Employer \_\_\_\_\_ Address \_\_\_\_\_  
 (Street) (City) (State) (Zip)

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

Company \_\_\_\_\_ Company \_\_\_\_\_

Policy Group # \_\_\_\_\_ Policy Group # \_\_\_\_\_

Workman's Comp  Company Name \_\_\_\_\_ Date of Injury \_\_\_\_\_

Address \_\_\_\_\_ Tel: \_\_\_\_\_  
 (Street) (City) (State) (Zip)

Payment Method  Cash  Check  MC/Visa

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. However, the financial agreement rests with you and not the insurance company.

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the Columbia Eye Clinic, P.A. for services rendered.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnoses and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

\_\_\_\_\_  
Patient's/Parents/Representative's Signature      Date

\_\_\_\_\_  
Witness Signature      Date

\_\_\_\_\_  
Printed Patient's or Representative's Name

\_\_\_\_\_  
Relationship to Patient

**AUTHORIZATION / RELEASE**

I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to Columbia Eye Clinic, PA / Columbia Eye Surgery Center, Inc. I hereby assign to Columbia Eye Clinic, PA / Columbia Eye Surgery Center, Inc. all payments for treatment services. *I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.*

I hereby authorize the release of medical information to Medicare, Medicaid, and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities I permit a copy of this authorization to be used.

\_\_\_\_\_  
Patient's/Parents/Representative's Signature      Date

\_\_\_\_\_  
Witness Signature      Date

\_\_\_\_\_  
Printed Patient's or Representative's Name

\_\_\_\_\_  
Relationship to Patient