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 **Date**