KNOXVILLE EYE SURGERY CENTER, LLC
Tennessee Valley Eye Center
140 Capitol Drive, Suite 2
Knoxville, TN 37922

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ Middle Initial ___

Billing Address____ Apt. # ______________

City_________________________________ State______ Zip __________

Please circle: Male / Female Date of Birth:________________ SSN#______________________________

Preferred Phone# 1st ( )______________ 2nd( )______________ 3rd( )______________

****Race and Ethnicity are required by the state of Tennessee****

Race: Please circle - White, Black or African American, Asian, Native American, Other

Ethnicity: Please circle - Not Hispanic, Hispanic, Hispanic Origin unknown

Marital Status: Please circle: S M W D

Please circle: Retired / Disabled / Unemployed / Employed

Employer Name____

Spouse Name: ___________________Please circle-Spouse: Retired / Disabled / Unemployed / Employed

Spouse Employer Name_______________________ Spouse SSN#_______________________________

Name of Emergency Contact (not living with you) Name_____________________________________

Phone# of contact ( )_________________ Relationship to Patient__________________________

Primary Insurance_________________________ Secondary Insurance_________________________

*** If you have MEDICARE, Please answer the next 8 questions ***

1) Are you entitled to Medicare based on age ☐Yes ☐No disability ☐Yes ☐No or end stage renal disease? ☐Yes ☐No

2) Do you have another insurance through your own employer? ☐Yes ☐No or a spouses employer? ☐Yes ☐No

3) Are you receiving Black Lung benefits? ☐Yes ☐No

4) Is this treatment a work related accident/condition? ☐Yes ☐No

5) Is this treatment due to an automobile accident? ☐Yes ☐No

6) Is this treatment due to an accident other than automobile? ☐Yes ☐No

7) Is treatment due to fault of another party? ☐Yes ☐No

8) Is this treatment covered under veterans administration? ☐Yes ☐No

Form completed by:____ _____________________
Signature/Relationship to patient Date

Patient's transportation home:____
Name/Phone#

**** If this is transportation service PLEASE notify the receptionist!**

If patient under 18
Name of Responsible Party________________________________ Phone # ( )______________

Relationship to patient___________________ Employer of Responsible Party_____________________