AMY R. LACKEY, O.D.
6940 Lee Highway, Suite 108 ◆ Chattanooga, TN 37421
Phone: 423-892-4900 ◆ Fax: 423-855-1496

PATIENT INFORMATION

Patient Name: ______________________________ **Date of Birth:** _____/_____/_____ **Age:** _____
Social Security #: _____ - _____ - _______ **Sex:** ❑ Male ❑ Female **Marital Status:** ❑ Single ❑ Married ❑ Widower ❑ Divorced
Mailing Address: ______________________________
STREET APT NO CITY STATE ZIPCODE
Home Phone: (_____) _____- _______ **Cell Phone:** (_____) _____- _______ **Email:** ______________________________
Best Way to Contact: ______________________________

Employer: ______________________________ **Work Phone:** (_____) _____ - _______
Employer Address: ______________________________
STREET CITY STATE ZIPCODE
Spouse's Name: ______________________________ **Date of Birth:** _____/_____/_____ **Age:** _____
Spouse's Social Security #: _____ - _____ - _______ **Spouse's Phone:** (_____) _____- _______

Emergency Contact: ______________________________ **Emergency Contact's Phone:** (_____) _____ - _______

GUARANTOR/PARENT INFORMATION

Responsible Party Name: ______________________________ **Date of Birth:** _____/_____/_____
Social Security #: _____ - _____ - _______ **Best Contact # for Guarantor/Parent:** (_____) _____- _______
Relationship to Patient: ______________________________

PATIENT'S INSURANCE INFORMATION ****Please provide insurance cards and photo I.D. to receptionist.****

Primary Insurance Company: ______________________________ **Name of Policy Holder:** ______________________________
Insurance ID #: ______________________________ **Insurance Group #:** ______________________________
Secondary Insurance Company: ______________________________ **Name of Policy Holder:** ______________________________
Insurance ID #: ______________________________ **Insurance Group #:** ______________________________
If you have any other health/eye insurance policies, please include information: ______________________________

Please answer the following questions to the best of your ability:

1) Are you seeing the doctor today due to an injury at work? ❑ Yes ❑ No If you checked yes, please explain below:
____

2) What is the main reason for seeing Dr. Lackey today? ______________________________
____

3) Were you referred to Dr. Lackey? ❑ Yes ❑ No If yes, please let us know who referred you. ______________________________
____

4) Who is your primary care physician? ______________________________

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Amy R. Lackey, O.D. to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I/We authorize Amy R. Lackey, O.D. to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE: ______________________________ **DATE:** _____/_____/_____
PATIENT (OVER 18 YEARS) OR RESPONSIBLE PARTY