EYEDENTITY

EYECARE + EYEWEAR

9671 N Nevada Street, Suite 210 Spokane, WA 99218 P:509-468-2020 F:509-468-3272

PLEASE PROVIDE US WITH A COPY OF YOUR CURRENT INSURANCE CARD AND VALID PICTURE ID

PATIENT INFORMATION

Name:(Last) _____(First)_____ (MI)_____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: ___M ___F Social Security #: _____ -_____- _____

Marital Status: ___Single ___Married ___Minor ___Widowed ___Divorced/Separated ___Partnered (for ___years)

Home Address:_____City:_____ State: _____ Zip:_____

Home Phone#:_____ ☐ Cell Phone#:_____ ☐ (Check p# best to reach you)

E-Mail:_____@_____._____ Okay to contact via e-mail: _____Yes_____No

Occupation: _____ Employer/School:_____

Business/School Address:_____ Business/School Phone#:_____

SPOUSE OR PARENT/GUARDIAN INFORMATION

Name:_____

Relationship to Patient: _____

Address (If different from above):

_____

City:_____ State: _____ Zip: _____

Home Phone#:_____

Cell Phone#:_____

Employer: _____

Employer Phone#:_____

REFERRAL INFORMATION

Whom may we thank for referring you:

_____

Friends/Family who are patients here:

_____

IN CASE OF EMERGENCY

(Please List someone who does not live with you)

Name: _____

Relationship:_____

Phone #: _____

INSURANCE INFORMATION

Name of Subscriber:_____ Relationship to Patient:_____

Primary Medical Insurance: _____ ID Number:_____

Vision Insurance (If different):_____ ID Number:_____

Method of Payment: _____Cash _____Check _____Credit/Debit

PAYMENT IS DUE, IN FULL, AT TIME OF SERVICE.

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our practice. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I certify that I have received the Notice of Privacy Practices from EyeDentity and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to: third-parties, payers, and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

Signature: _____ Date: _____