



PATIENT INFORMATION Please Print

Patient ID# _____

Patient's Name: _____
First Initial Last

Date of Birth: _____ Age: _____

Social Security #: _____ Sex: []M []F

Marital Status: []Married []Single []Divorced []Widowed

Mailing Address: _____

City, State, Zip: _____

E-mail Address: _____

County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a message at your home or cell number? Yes No

Occupation: _____ Employer: _____ Phone: _____

Referring Physician: _____ Personal/Family Physician: _____

Spouse's Name: _____

RESPONSIBLE PARTY INFORMATION

Adult accompanying minor (17 years of age or under) is responsible party

Responsible Party: _____

Patient Relationship: _____

Date of Birth: _____

Social Security #: _____

Address: _____

City, State, Zip: _____

Employer: _____

Phone: _____

EMERGENCY CONTACT

Please give name and phone number of a friend or relative that does not live at your present address.

Name: _____

Phone: _____

Relationship: _____

Person(S) Who(M) We May Share Your Healthcare Information With: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Name: _____

Insurance Name: _____

Subscriber Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Subscriber ID#: _____

Date of Birth: _____

Date of Birth: _____

Group Number Certificate Number

Group Number Certificate Number

Insurance Authorization and Assignment (PLEASE READ)

I authorize Rocky Mountain Eye Center, P.C. to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third party payers.

I authorize treatment of the person named above, I CERTIFY THAT I AM THE PATIENT OR THE LEGAL GUARDIAN OF THE PATIENT, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable. The above information is for the purpose of extending credit and is warranted to be true. I have received a copy of "In Case of Errors or Inquires About Your Bill".

X _____
Patient / Responsible Party Signature

X _____
Date