blainefamilyeyecare

Date: _____

Welcome to our office! We are delighted to have you as a patient and appreciate the confidence you placed in choosing us as your eyecare provider. Please complete the following data for our records.

PATIENT DEMOGRAPHIC INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Preferred Name (if different than first name)

Date of Birth _____ Age _____ Gender M F

Address _____

City_____ State_____ Zip_____

Cell Phone _____ Home Phone _____ Work Phone _____

Emergency Contact _____ Phone _____

Email (used for reminders and special events) _____

Occupation_____

Sports/Hobbies_____

How did you hear about our office?

☐ Insurance ☐ Drive by ☐ Internet search
☐ Friend/Family _____ ☐ Other_____

INSURANCE INFORMATION

Medical Insurance Carrier _____ Vision Insurance _____

If your insurance policy is not in your name, please provide the following:

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Last 4 digits of Policy Holder's Soc Sec #_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child – Is child full time student? Yes No

I authorize Blaine Family Eye Care to release or exchange any information necessary to process my insurance claims. I request that payment of authorized benefits, including Medicare, be made to this clinic for services furnished me by any provider employed by this clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage.

X _____ _____

Signature of patient or guardian date

ACKNOWLEDGEMENT OF HIPPA PRIVACY ACT

At Blaine Family Eye Care we keep a record of the health care services we provide to you. You may request a copy of your medical record in writing or get more information by contacting our privacy officer. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

_____ I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.