



Patient Demographic Information

Name: _____ Birth Date: _____
 First M.I. Last

Address: _____
 Mailing Address City State Zip

Phone #1: _____ Phone #2: _____ Male / Female

Email Address: _____ **Age:** _____ **SSN** _____ **Marital Status:** _____

If you are a new patient, how did you hear about us? (Please list name).. _____

Referring Physician: _____ Location: _____

Primary Care Physician: _____ Location: _____ **Ok to Fax Records: YES / NO**

Pharmacy: _____ Location: _____

Patient Relationship to Responsible Party: Self Spouse Child Other

Name of Spouse or Parent (if patient is a minor): _____ Birth Date: _____

Emergency Contacts: **Medical Information may also be shared with the following contacts: YES / NO**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Note: Limitations on sharing your medical information may be indicated on your signed Notice of Privacy Practices acknowledgement form.

Does patient have insurance? Yes No (if yes, please complete insurance information on page 2)

Signature of Patient or Parent/Guardian

Date



Insurance Information

Patient: _____

Primary Insurance: _____ ID #: _____

Name of Subscriber: _____ DOB: _____

Secondary Insurance: _____ ID #: _____

Name of Subscriber: _____ DOB: _____



Due to the passage of certain health initiatives as a medical provider utilizing electronic medical records (EMR) are required to collect the following information effective December 2010.

<u>Language</u> _____	<u>Ethnicity</u> _____	<u>Race</u> _____
Dutch	Hispanic or Latino	American Indian or Alaska Native
Chinese	Not Hispanic or Latino	Asian
English		Black or African American
Japanese		Native Hawaiian or other Pacific Islander
Russian		White
Spanish		



Insurance Billing

We verify and bill your insurance as a courtesy. However, insurance verification is not a guarantee of payment. Copies of insurance cards, name and birth date of the insurance subscriber for each family member at each visit are necessary for accurate and timely insurance billing.

Payment

All fees for services not covered and/or paid by insurance including co-payments, co-insurance, and deductibles will be the responsibility of the patient or responsible party at the time services are rendered.

Acknowledgement of Our Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Cascade Eye Associates Notice of Privacy Practices. By signing below I am “only” giving acknowledgement that I have received or have had the opportunity to receive the notice of our Privacy Practices.

Photo Identification

In an attempt to protect our patients from identity theft, we are asking for photo ID at registration and scanning into your medical chart. We will make every effort to verify your identity at each consecutive appointment.

I hereby authorize Cascade Eye Associates or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purpose of collection professional fees on my behalf. I assign all benefits payable to Cascade Eye Associates. To the best of my knowledge this information is accurate as of this date. I accept full responsibility for all changes related to my treatment that are not covered by my insurance.

Signature of Patient, Parent/Guardian

Date