Rocky Mountain EYE CENTER

PATIENT INFORMATION *Please PRINT In BLACK Ink*

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) with who(m) we may share your healthcare information: _____

PRIMARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

Group Number _____ **Certificate Number** _____

SECONDARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

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. All past due accounts will be charged 10% interest per year. 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_____ **X**_____

Patient / Responsible Party Signature **Date**