WELCOME TO OUR OFFICE

We are very happy and pleased to welcome you to our office. We trust you will feel confident in the vision care you receive while a patient here.

PATIENT INFORMATION

Name ____________________

If married, name of spouse ____________________

Address ____________________

City ____________ State ______ Zip ________

Home # ____________ Sex F or M

Work # ____________ Birth Date ________

Cell # ____________ SS# ________

E-mail ____________________

Marital Status: Single Married Minor Separated Divorced Widowed

Why did you choose our office?

☐ Yellow Pages ☐ Newspaper ☐ Mailing

☐ Referred by Someone Who: ____________

RESPONSIBLE PARTY INFORMATION

Responsible Party Name ____________________

Address ____________________

City ____________ State ______ Zip ________

Relationship to Patient ____________________

Phone # ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name ____________________

Home # ____________ Work # ____________

Relationship to Patient ____________________

EMPLOYER INFORMATION

Company ____________________

Address ____________________

____

Phone # ____________________

Occupation ____________________

INSURANCE INFORMATION

Primary Company ____________________

Policy Holder ____________________

Group # ____________ Plan # ____________

Policy or ID # ____________________

Birth Date ____________ SS # ____________

I understand it is my responsibility to pay co-pays at the time of service.

I understand that I am financially responsible for payment of any services provided, and which are not covered by my insurance, including but not limited to, deductible and co-insurance.

I request that payment of authorized insurance benefits, including Medicare, be made to Morrison Eye Care for any services furnished to me by any provider employed or contracted by this office.

I authorize Morrison Eye Care to release any medical information about me needed to process claims, determine benefits or the benefits payment for related services to my insurance companies, including insurance company agents or the Center for Medicare and Medicaid Services.
I also authorize Morrison Eye Care to release any medical information about me to other health care providers who are involved in my treatment.

Morrison Eye Care is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Morrison Eye Care Notice of Privacy Practices.
This authorization will remain in effect until revoked by me in writing.

Signature ________________________________ Date ____________

Patient or legal guardian if patient is a minor

Relationship to patient ____________