Morrison Eye Care
Detroit Lakes - Mahnomen

WELCOME TO OUR OFFICE

We are 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 _____

Marital Status: Single Married Minor Separated Divorced Widowed

If married, name of spouse _____

Address _____

City_____ State _____ Zip_____

Sex: __F __M Date of Birth_____

SSN_____

Home #_____ Cell # _____

E-mail_____

Preferred Method of Contact: ____Call ____Text ____ Email

Why did you choose Morrison Eye Care?

___ yellow pages ____ Newspaper ____ Mailing ____ Internet/Facebook

___ Referred by someone – Who: _____

If not self, Responsible Party

Name _____

Address _____

City_____ State _____ Zip_____

Sex: __F __M Date of Birth_____

SSN_____

Home #_____ Cell # _____

Preferred Method of Payment

____ Self-Pay ____ Insurance _____ Workman's Comp

Emergency Contact

(Who should we contact in case of an emergency?)

Name _____

Address _____

City_____ State _____ Zip_____

Home #_____ Cell # _____

Lifestyle

Company _____

Occupation _____

Address _____

City_____ State _____ Zip_____

HR Contact Person _____

Phone # _____

Hobbies & Interests:

___ Traveling ___ Fishing/Hunting/Archery ___ Computer/Tablet

___ Sports (football, basketball, baseball, tennis, golf, etc.)

___ Reading/Writing/Blogging ___ Swimming/Diving

___ Exercise (walking, running, yoga, cycling, etc.)

___ Other: _____

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.

I authorize the release of information relating to the diagnosis, treatment, and claim information be released to:

____ Spouse: _____

____ Parent: _____

____ Child/ren: _____

____ Other: _____

____ Information is not to be released to anyone.

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 as 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. _____(initials)

I acknowledge that I have read and understand the information outlined in the Morrison Eye Care Financial Policy. I agree to pay for services and materials in which I order. _____(initials)

_____ _____

Patient Signature Date