WELCOME

PATIENT INFORMATION

Date ___________________
Name _______________ MI ____ __________________
Nickname _______________________
Date of Birth ___________________ ◻ Male ◻ Female
Address ____
City ____
State ___________ Zip ___________
Social Security # __________________________________
E-Mail ____
◻ Minor ◻ Single ◻ Married ◻ Widowed
◻ Legally Separated ◻ Divorced

Home Phone _______________________
Work Phone ________________________
Cell Phone _________________________
Employer/School ____________________________
◻ Full Time ◻ Part Time ◻ Student ◻ Retired

Spouse's Name ______________________________
Spouse's Date of Birth ___________________________
Spouse's SS# _______________________________
Spouse's Employer __________________________

If minor, name of parent(s)/guardian(s) ____

PERSON RESPONSIBLE FOR ACCOUNT

◻ Same as Patient ◻ Other than Patient (Please complete info below)

Name ____
Date of Birth ___________________
Address ____
State ___________ Zip ___________

Employer _____________________________________
Daytime Phone _________________________________
Relationship to Patient ___________________________

CASH PAYMENT

We offer a time of service discount on examinations and diagnostic procedures **if paid on the day of service** (does NOT include Optomap or contact lens service fee). This represents the savings in time and resources to us for not becoming involved in billing you or an insurance company. ◻ I have read and prefer this option

VISION INSURANCE

Insurance Co. __________________________________
ID # __________________________________
Group # _______________ Date of Birth ______________
Subscriber ______________________________________
Relationship to Patient ___________________________
Subscriber's Address ____________________________

MEDICAL INSURANCE

Insurance Co. __________________________________
ID # __________________________________
Group # _______________ Date of Birth ______________
Subscriber ______________________________________
Relationship to Patient ___________________________
Subscriber's Address ____________________________

IS PATIENT COVERED BY ANOTHER INSURANCE?

◻ Yes ◻ No
Insurance Co. _________________________________
ID # ____

Group # ____________________________________
Subscriber Name ______________________________
Relationship to Patient _________________________

MEANINGFUL USE

Language ◻ English ◻ Spanish ◻ Other
Race ◻ American Indian/Alaskan Native ◻ Black or African American
◻ Native Hawaiian/Pacific Islander ◻ White/Caucasian
◻ Asian ◻ Hispanic ◻ Russian ◻ Other ____________________

Ethnicity ◻ NOT Hispanic or Latino ◻ Native Hawaiian/Pacific Islander
◻ Hispanic or Latino ◻ Other _________________ ◻ Decline

Preferred Communication ◻ Email ◻ Postal ◻ Telephone

IF YOU ARE NEW TO OUR OFFICE, WHOM MAY WE THANK FOR REFERRING YOU? ______________________________________

IF NOT REFERRED, HOW DID YOU SELECT OUR OFFICE? ◻ Insurance Company ◻ Community Directory ◻ Marketing Pamphlet ◻ Splash ◻ Sign/Building ◻ Yellow Pages ◻ Our Website

Assignment and Release

I certify that I, and/or my dependents have insurance with the above named insurance company(ies) and assign directly to Liberty Lake EyeCare Center, P.S., Dr. Ulrich, and/or Dr. Balani, all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions. Dr. Ulrich and Dr. Balani may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signed ____ Date ______________________