

OREGON TRAIL EYE CENTER P.C.
329 West 40th Street
Scottsbluff, NE 69361
308-635-3911 or 1-800-383-3351

PATIENT INFORMATION

PATIENT'S NAME _____ DATE _____
(Mr, Mrs, Ms, Miss)
PATIENT'S ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME TELEPHONE: _____ WORK TELEPHONE: _____
ALTERNATE TELEPHONE #: _____
PATIENT'S BIRTHDATE _____ SEX: M F
PATIENT'S SOCIAL SECURITY NUMBER _____
MARITAL STATUS: Single Married Widowed Divorced Legally separated
PATIENT'S FAMILY PHYSICIAN _____
PATIENT'S OPTOMETRIST _____
REFERRED BY _____

RESPONSIBLE PARTY

RESPONSIBLE PARTY'S EMPLOYER _____
EMPLOYER'S ADDRESS _____
WORK TELEPHONE _____ OCCUPATION _____
RESPONSIBLE PARTY _____ RELATIONSHIP _____
(Only if different than above)
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____ SOCIAL SEC. # OF RESPONSIBLE PARTY _____

INSURANCE
SECONDARY PAYOR

POLICY HOLDERS NAME _____ POLICY # _____
1) PRIMARY INS. COMPANY _____
INS. ADDRESS _____
CITY _____ STATE _____ ZIP _____
SECONDARY INSURANCE: POLICY NUMBER _____
2) SECONDARY INS. COMPANY _____
INS. ADDRESS _____
CITY _____ STATE _____ ZIP _____
 Veteran Federal Black Lung Program Accident injury Date: _____ Description: _____

AUTHORIZATION

I request that payment of medical benefits be made on my behalf to the Oregon Trail Eye Clinic for any services which are provided to me by Dr. Judson C. Martin or Dr. Thomas J. Roussel.

I authorize any holder of medical information about me to release to the Health Care Financing Administration or other Health Care Organization and its agents any information needed to determine their benefits. I understand that if the balance is my responsibility, a monthly rebilling charge may be added to my account until the balance is paid in full.

Patient's Signature (parent of minor, legal representative, etc.) Relationship (to patient) Date