OREGON TRAIL EYE CENTER, PC

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 *(If different than above)*

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 Oregon Trail 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 collection agencies, insurance companies and third party payers.

I request that payment of medical benefits be made on my behalf to the Oregon Trail Eye Center PC for any services provided to me by Dr. Thomas J. Roussel, Dr. Shawna R. Collier, Dr. Keegan A. Harkins or Dr. Brian L. Colburn. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other Health Care Organizations and it's agents any information needed to determine their benefits. I understand that if the balance is my responsibility.

I authorize treatment of the person named above, I CERTIFY THAT I AM THE PATIENT OR 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.

X_____ **X**_____

Patient / Responsible Party Signature **Date**

Clear & Reset Form

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