

# SPOKANE EYE CLINIC PATIENT INFORMATION FORM

All information required. If not applicable, please write N/A.  
**PLEASE PRINT / WRITE LEGIBLY**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_  
(circle: Mr., Mrs., Ms., Miss, Dr.)

**Address:** \_\_\_\_\_  
Street Address/PO Box # City State Zip

**Patient Home Phone:** ( ) \_\_\_\_\_ **Patient Age:** \_\_\_\_\_  M  F

**Patient Cell Phone** ( ) \_\_\_\_\_ **Patient Date of Birth** \_\_\_\_\_

**Patient Email Address (required):** \_\_\_\_\_

\*We abide by all HIPAA privacy regulations and do not sell or market your demographic information, including your e-mail address, to anyone.

**Patient Employer:** \_\_\_\_\_ **Employer Phone:** ( ) \_\_\_\_\_

**Name of Spouse:** \_\_\_\_\_ **Spouse Employer:** \_\_\_\_\_

**Patient SS#:** \_\_\_\_\_ **Person Responsible for Payment:** \_\_\_\_\_

**IF PATIENT IS A CHILD:**

**Father's Name:** \_\_\_\_\_ **Mother's Name:** \_\_\_\_\_

**Father's SS#:** \_\_\_\_\_ **Mother's SS#:** \_\_\_\_\_

**Father's Employer:** \_\_\_\_\_ **Mother's Employer :** \_\_\_\_\_

**Father's Employer Phone:** ( ) \_\_\_\_\_ **Mother's Employer Phone:** ( ) \_\_\_\_\_

**Primary Care Physician (PCP):** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Pharmacy Address:** \_\_\_\_\_

**Referring Physician Address:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

**Referring Physician Phone:** ( ) \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Insurance:** \_\_\_\_\_ **Policyholder's Name:** \_\_\_\_\_

**Policyholder's ID#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Policyholder's Name:** \_\_\_\_\_

**Policyholder's ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Work Related: Yes / No** **Date of Injury:** \_\_\_\_\_ **L&I Carrier:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Assignment of Benefits:** I hereby assign payment of medical and/or surgical benefits be made to me or on my behalf to Spokane Eye Clinic for any services furnished me by that facility. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_