Chart Page # _____
Asst. Initials _____

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: _____