# SEATTLE EYE M.D.s - New Patient Information

**PERSONAL INFORMATION** **(Please Print)** Date _____

Last Name _____ First _____ MI _____

Date of Birth ___/___/_____ Sex Male / Female Soc Security # _____

Address _____
Street City State Zip

Phone: Home (___) _____ Work (___) _____

E-Mail Address _____

Occupation _____ Employer _____

Address _____ Phone (___) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer _____

Address _____ Phone (___) _____

**Name of Primary Care Physician** _____

**Referred by :** ☐ Friend/Relative/Doctor _____ ☐ Walk-In
Name

☐ Yellow Pages ☐ QwestDex ☐ Citysearch ☐ Other _____

**Complete if under 18 years or a student**

Name of Father/Mother _____ Employer _____

Address _____
Street City State Zip

Home Phone (___) _____ Work Phone (___) _____

**INSURANCE INFORMATION**

Name of Policy Holder _____ DOB ___/___/_____

Primary Insurance (incl. Medicare) _____

Group # _____ ID# _____ Phone (___) _____

Secondary Insurance _____

Group # _____ ID# _____ Phone (___) _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____

**EMERGENCY CONTACT:** Who to notify in case of emergency (nearest relative or friend)?

Name _____ Relationship _____

Home Phone (___) _____ Work Phone (___) _____

**FINANCIAL ASSIGNMENT AND AGREEMENT:**

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. 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.

**Signed** (Patient or parent if minor) _____ Date _____