

**EYE CLINIC OF BELLEVUE, LTD, P.S.**

1300 116TH AVENUE N.E. • BELLEVUE, WA 98004

- NEW PATIENT
- UPDATE

- J.T. COYLE, M.D.
- JOHN D. GOFMAN, M.D.
- JAMES L. STROH, M.D.
- G.T. REAVELL, M.D.
- ANDREW P. DAVIS, M.D.
- STEPHANIE T. PHAN, M.D.
- KENT L. BASSETT, M.D.
- RUTH W. MILLER, M.D.
- MICHAEL RIZEN, M.D., PhD.

**PATIENT REGISTRATION**

PLEASE PRINT

LEGAL NAME OF PATIENT \_\_\_\_\_  

LAST NAME
FIRST NAME
M.I.

SOCIAL SECURITY NO. \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX  MALE  FEMALE

HOME ADDRESS \_\_\_\_\_ APT NO. \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ PHONE NO. (\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE NO. (\_\_\_\_) \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ CITY \_\_\_\_\_

**FILL OUT THIS SECTION ONLY IF DIFFERENT THAN PATIENT**

PARENT OR RESPONSIBLE PARTY \_\_\_\_\_  

LAST NAME
FIRST NAME
M.I.

RELATION TO PATIENT \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

**MEDICAL INSURANCE**

**VISION INSURANCE  
(If different than medical)**

PRIMARY \_\_\_\_\_

SUBSCRIBER NAME & BIRTHDATE \_\_\_\_\_

SECONDARY \_\_\_\_\_

SUBSCRIBER NAME & BIRTHDATE \_\_\_\_\_

PRIMARY \_\_\_\_\_

SUBSCRIBER NAME & BIRTHDATE \_\_\_\_\_

SECONDARY \_\_\_\_\_

SUBSCRIBER NAME & BIRTHDATE \_\_\_\_\_

WORK RELATED INJURY STATE INDUSTRIAL CLAIM NO. \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

**Please present insurance card(s) to the receptionist.** If your insurance carrier is contracted with the Eye Clinic of Bellevue, only the applicable copayment is due. If copayment is not paid at the time of service, a \$5.00 fee will be incurred.

**Otherwise, charges are due and payable at the time of service unless other arrangements are made.**

Preferred method of payment:  Cash  Check  Credit Card (Mastercard/Visa)  
A \$15.00 fee will be charged for non-sufficient funds or account closed checks returned to the Eye Clinic.

**LIFETIME AUTHORIZATION**

I request that payment of authorized Medicare, or of insurance benefits listed above, be made on my behalf to the Eye Clinic of Bellevue for any services furnished me by the Eye Clinic of Bellevue. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION (or other insurance listed above) and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNED **X** \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_