Eye Clinic of Bellevue

We welcome you as a patient

We at the Eye Clinic of Bellevue thank you for taking the time to complete this form, and we apologize for any inconvenience. Due to recent government initiatives to promote the use of an electronic health record, and in compliance with Meaningful Use, the reporting of a patient's racial background, ethnicity, and preferred language, is now a requirement. If you are uncomfortable answering these questions, you may indicate, "Declined to Report".

Legal Name of Patient_____ Birthdate_____ ☐ Male ☐ Female
Last Name First Name M.I.

Email _____ Responsible Party_____

Mailing Address_____ Apt No. _____

City _____ State _____ Zip _____ Home Phone (_____)_____

Employer_____ Work Phone (_____)_____ Cell Phone (_____)_____

Emergency Contact Person_____ Phone No. (_____)_____

Primary Care Physician_____ Phone No. (_____)_____

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to Report

Race: _____ American Indian or Alaska Native _____ Asian _____ Native Hawaiian/Other Pacific Islander

_____ African American _____ Caucasian _____ Other _____ Declined to Report

Preferred language _____ Preferred method of communication: ☐ Letter ☐ Patient portal

☐ Cell phone-may leave message ☐ Cell phone-do not leave message

☐ Home phone-may leave message ☐ Home phone-do not leave message

☐ Work phone-may leave message ☐ Work phone-do not leave message

I understand that I may request a copy of the HIPAA (Health Information Portability and Accountability Act) policy, also available at eyeclinicofbellevue.com. I authorize release of relevant medical information to the following person(s):

Name _____ Relationship_____

Name _____ Relationship_____

Signed **X** _____ Date _____/_____/_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Primary Medical Insurance _____

Does your insurance require a referral ☐ Yes ☐ No

Subscriber's Name (if not patient) _____

Subscriber's Date of Birth _____/_____/_____ M or F

Relationship to Patient: Self Spouse Parent

Secondary _____

Subscriber's Name (if not patient) _____

Subscriber Date of Birth _____/_____/_____ M or F

Relationship to Patient: Self Spouse Parent

Vision Insurance _____

Subscriber's Name (if not patient) _____

Subscriber Date of Birth _____/_____/_____ M or F

Relationship to Patient: Self Spouse Parent

Vision Plan ID #: _____

(The ID number is the subscriber's social security number for many vision plans)

Injury Information

Is your visit today injury related ☐ Yes ☐ No

Place of Injury ☐ Home ☐ School ☐ Work ☐ Auto ☐ Other

Date of Injury _____

Please present insurance card(s) to the receptionist. If your insurance carrier is contracted with Eye Clinic of Bellevue, the applicable copayment is due at the time of service. If you do not have insurance or we are not contracted with your insurance carrier, please ask about our discount for payment at the time of service. A $15.00 fee will be charged for non-sufficient funds or account closed checks, and past due balances are subject to a $5.00 rebilling fee.

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 _____/_____/_____