

How did you hear about us? Please Circle

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Whom may we thank for referring you? \_\_\_\_\_

Date \_\_\_\_\_ Account # \_\_\_\_\_

**PATIENT IDENTIFICATION: (please print)**

Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Miss \_\_\_\_\_ Ms \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cellular Phone: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Place of Work \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Person to notify (Name and relationship of friend or relative not residing with you):

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**RESPONSIBLE PERSON:**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**\*INSURANCE (please present your cards to the receptionist):**

**FOR INSURANCES WE ARE CONTRACTED TO BILL:**

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to NORTH IDAHO EYE INSTITUTE, COEUR D'ALENE OPTICAL, AND NORTH IDAHO CATARACT AND LASER CENTER for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the health Care Financing Administration/my insurance company and its agents, any information needed to determine these benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT OF MINOR LACKING CAPACITY TO CONSENT:**

I will authorize North Idaho Eye Institute Physicians to provide medical care, including examination, treatment, X-ray examination, laboratory tests, local anesthetics, medical diagnosis, and hospital care to \_\_\_\_\_, a minor. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the afore mentioned doctors.

This authorization will remain in effect until the minor turns 18 or consent is revoked in writing.

Signature of Parent/Legal Guardian/Person Having Custody \_\_\_\_\_

Printed Name of Parent/Legal Guardian/Person Having Custody \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_