Tad Buckland, MD | Alison Granier, MD | David Dance, MD | Sara Duke, MD | Justin StormoGipson, MD
Whitney Smith, MD | Drew Thomas, MD | John Weisel, OD | John Calderwood, OD

Coeur d'Alene – Hayden – Post Falls
Phone: (208) 667-2531 Fax: (208) 765-9385

PATIENT INFORMATION

Patient ID# ______________

Patient's Name: ______________ (First) ______________ (Initial) ______________ (Last) Date of Birth: ______________ Age: ______

Social Security #: ______________ Sex: [ ]M [ ]F Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Mailing Address: ______________ City: ______________ State: ________ Zip: ________

E-mail Address: ______________ County: ______________

Home Phone: ______________ Cell Phone: ______________ Preferred: Home Cell

☐ I **do not** want text messages for appointment reminders sent to my cell phone number listed above.

Race: [ ] White [ ]American Indian or Alaska Native [ ]Pacific Islander [ ]Black or African American [ ] Asian Other Race: ________

Ethnicity: [ ] Hispanic [ ] Non-Hispanic or Latino [ ] Decline Language: ______________

Occupation: ______________ Employer: ______________ Phone: ______________

Referring Physician: ______________ **Personal/Family Physician**: ______________

EMERGENCY CONTACT

Please give name and phone number of a friend or relative that does not live at your present address.

Name: ______________ Phone: ______________

Relationship: ______________

Person(s) with who(m) we may share your healthcare information: *(If left blank, we will not share any patient information)*

Name: ______________ Date of birth: ______________

Name/Facility: ______________ Date of birth: ______________

Preferred Pharmacy: ______________ City: ______________

Responsible Party Information

☐ Same as patient information listed above.

Responsible Party: ______________ Patient Relationship: ______________

Date of Birth: ______________ Social Security #: ______________

Address: ______________ City, State, Zip: ______________

Employer: ______________ Phone: ______________

PRIMARY INSURANCE

PRIMARY INSURANCE		______________
Insurance Name:	______________	______________
ID Number:	______________	______________
Group Number:	______________	______________
Subscriber Name:	______________	______________
Date of Birth:	______________	______________

PLEASE COMPLETE OTHER SIDE

Insurance Authorization Agreement

I authorize North Idaho Eye Institute, North Idaho Cataract and Laser Center, and/or Coeur d'Alene Optical DBA Post Falls Eye Clinic, Post Falls Optical, Coeur d Alene Eye Clinic to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution, and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third-party payers.

I authorize treatment of the person named above, I certify that I am the patient or legal guardian of the and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless payment arrangements are made. I understand that I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable.

Insurance and Financial Statement

North Idaho Eye Institute P.A, Post Falls Eye Clinic, North Idaho Cataract & Laser Center all accept Medicare, Medicaid as well as many commercial insurances. If you do not have insurance, or a secondary insurance that covers your deductible and/or coinsurance, you will be expected to pay your copay and/or coinsurance at the time of service.

Refractions are not covered by Medicare and may not be covered by your insurance. You are responsible for the refraction charge of $45.00 and is due at the time of service.

It is the patient's responsibility to ensure that appropriate referral information from the insurance company is sent to our office before your visit. If referral is not present at the time of service, you may be asked to re-schedule.

Idaho Medicaid does not provide routine vision care to patients over the age of 21. By signing below, you agree to and understand that you will be financially responsible for routine vision care provided.

If you have any questions, or need to set up payment arrangements please contact our business office at 208-667-5540. I hereby certify that I have read the above agreement and statement and agree to adhere to the terms above.

I have reviewed the above policies and information and verify that the information I provided is the correct information to the best of my knowledge.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of Provider's Notices of Privacy Practices with the effective date of 9/5/2018.

Patient printed name: ____

Patient signature:____Date:__________________________

Employee Initials: ___________

Form updated: 8/8/2019