INTERMOUNTAIN EYE CENTERS PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ M.I.: _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ ZIP: _____

Phone No.: (_____) _____Cell No: (___) _____ Social Security No.: _____

Employer: _____ Work Phone: (_____) _____ Ext.: _____

Birth Date: ____/____/____ Sex: ❑ Female ❑ Male Referred By: _____

Primary Care Physician: _____ Has any other family member been seen? ❑ No ❑ Yes

If yes, please enter name: _____ Relationship to Patient: _____

Do you wear ☐ glasses and / or ☐ contacts? ☐ Yes ☐ No Are you interested in contacts? ☐ Yes ☐ No
Are you interested in LASIK? ☐ Yes ☐ No

GUARANTOR (Person Responsible For Account)

Last Name: _____ First Name: _____ M.I.: _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ ZIP: _____

Phone No.: (_____) _____ Social Security No.: _____

Employer: _____ Work Phone: (_____) _____ Ext.: _____

Birth Date: ____/____/____ Relationship to Patient: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Claims Street Address: _____

City: _____ State: _____ ZIP: _____

Phone No. (for verification): (_____) _____

Name of Policy Holder: _____ Birth Date: ____/____/____

Employer: _____

Subscriber No.: _____ Group No.: _____

Medicare No.: _____ Idaho Medicaid No.: _____

INSURANCE BILLING POLICY

Our policy is payment at the time of service unless other arrangements have been made in advance. Your insurance policy is a contract between you and your carrier. However, for your convenience we will submit your claim to your insurance company. If the insurance company forwards payment to our office, you will be reimbursed for overpayment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Intermountain Eye Centers to release any information needed to my insurance carrier to determine benefits payable for related services. I hereby assign Intermountain Eye Centers all payments for medical services rendered to myself and / or my dependants.

SIGNATURE: _____ DATE: _____