INTERMOUNTAIN EYE CENTERS PATIENT INFORMATION SHEET

Last Name:	First Name:	M. I.:
Street Address:		Apartment #:
City:	State:	ZIP:
Phone No.: ()Cell 1	No.: ()Email: _	
Employer:	Social Security No).:
Date of Birth:/ Sex: □ Fe	emale 🗆 Male 🗆 Refe	rred by:
Primary Care Physician:	Has any other family men	nber been seen? θ No θ Yes
If yes, please enter name:	Relationship to Patient: _	
Do you wear □ glasses and/or □ contact	Are you interes	ted in contacts? ☐ Yes ☐ No
Are you interested in learning more abou	t □ refractive surgery or laser □	cosmetic eyelid procedures?
GUARANTO	OR (Person Responsible For Acc	count)
Last Name:	First Name:	M.I.:
Street Address:		Apartment #:
City:	State:	ZIP:
Phone No.: ()Cell 1		
Employer:	Work Phone: ()	Ext:
Birth Date:/ Relationshi	p to Patient:	
Our policy is payment at the time of ser insurance policy is a contraction betwee submit your claim to your insurance com	en you and your carrier. Howe	ver, for your convenience we will
will be reimbursed for overpayment.		
	E AUTHORIZATION AND ASSIGN	
I authorize Intermountain Eye Centers determine benefits payable for related so medical services rendered to myself and	ervices. I hereby assign Intermou	•
Signature:		Date:
C' .		D