Patient Registration

Patient Name: _____ Date of Birth: _____

Guardian: _____ ____ Todays Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SSN: _____

Marital Status: Married Single Other:_____ Sex: M F

Occupation: _____ Retired Student

Employer: _____ Spouses Name: _____

How did you hear about our office?

Google Facebook Kuna Melba News Street Signage Patient/Relative/Physician..... Who? _____

May we leave a brief message on your home or cell phone? _____

May we leave an extended message on your home or cell phone? _____

May we leave a message for you at work to call us? _____

May we discuss your medical treatment with another person? YES NO
If, yes, whom? _____

Primary Medical Insurance: _____ Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____ DOB: _____

Secondary or Vision Insurance:_____ Policy/ ID #: _____ SSN: _____

Policy Holder Name: _____ Relationship to Patient: _____ DOB: _____

Release of Information / Financial Guarantee:

I give my permission to ClarifEye Family Eyecare to bill my insurance company whether the benefits are to come to me or to ClarifEye Family Eyecare. It is my understanding that I am eligible for medical or vision benefits through my insurance. However, in the event that my insurance company categorizes services rendered to me as "non covered", I agree to pay in full for all such charges. I fully understand that it is my responsibility to advise ClarifEye Family Eyecare if my insurance contains any special provisions which must be satisfied before payment by the insurance company is made. If I fail to advise ClarifEye Family Eyecare of such policy requirements and to comply in good faith, I agree to pay in full for such charges. If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Doctor (copays will be made at the time of service). I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Doctor.

We are required by law to provide to you a notice of our Privacy Practices. Additional details of our Privacy Practices are available at the front counter and on our website: www.ClarifEyeEyecare.com. Please sign below indicating that you've had access to our Privacy Practices.

The signature below authorizes direct assignment of benefits to ClarifEye Family Eyecare

Patient Signature: _____ Date: _____