THE EYE CENTER OF PARKVILLE PATIENT INFORMATION

DEMOGRAPHICS

Name _____ Birth Date _____
LAST FIRST MI

Street Address _____

City _____ State _____ Zip Code _____

Best Phone Number _____ Email _____

Social Security Number _____ Gender _____

Emergency Contact: Name _____ Phone _____

Occupation _____

BILLING INFORMATION

Primary Insurance Policy Holder Name _____ Phone _____ Date of Birth_____

Financially Responsible Party for Minors under 18 _____ N/A

Address (if different from above) _____

Relationship to Patient (Circle one) SELF SPOUSE PARENT OTHER

I understand and acknowledge all of the following:

- ☐ The Eye Center of Parkville follows HIPAA laws that protect your personal health information. I have been offered a copy of the Notice of Privacy Practices (HIPAA).
- ☐ I authorize The Eye Center of Parkville to bill my insurance company and receive payments.I also authorize The Eye Center of Parkville to release any information needed for the processing of my claim. I authorize the payment of medical benefits to the billing provider at The Eye Center of Parkville.
- ☐ I understand I am financially responsible for all copays, deductibles and coinsurance amounts.
- ☐ I understand that payment for all optometric professional services is due at the time of service.
- ☐ I understand that payment for eyeglasses and contact lenses is due at the time of ordering.
- ☐ I consent to a detailed message left on voicemail: × YES × NO
- ☐ I would like to receive my appointment reminders by: × EMAIL × TEXT

Reason for your visit today: _____

Any new vision concerns(eg: new floaters,flashes of light, itchy or red eyes):

_____

Any new health symptoms or concerns: _____

_____ _____
Patient/Parent/Guardian Signature Date