CASCADE EYE CENTER

Welcome!

Patient Information

Male ❑

Title: _____ Name: _____ DOB: _____ Female ❑
FIRST M.I. LAST

I prefer to be called: _____ SSN: _____ Marital Status: M D W S

Mailing Address: _____
STREET CITY STATE ZIP CODE

Phone: _____ Work: _____ Cell: _____

Name of Parent/Guardian (if patient is a minor): _____ Phone: _____

Emergency Contact: _____ Phone: _____
NAME RELATIONSHIP

Employer: _____ Occupation: _____ Phone: _____

Name of Responsible Billing Party: _____ Date of Birth: _____

Address of Responsible Billing Party: _____

Patient Relationship to Billing Party: ❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Referring Physician: _____ Primary Care Physician: _____

Race (Ancestry): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ White or Caucasian
❑ Native Hawaiian or Other Pacific Islander Preferred Language: _____

Ethnicity (Place of Origin): ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Other

If you are a new patient, how did you hear about us?

Phone Book Radio Newspaper Drive By Web Insurance Company Friend _____

Do you have VISION or MEDICAL INSURANCE? ❑ Yes ❑ No *IF YES, Please complete the Insurance Information Sheet*

PAYMENT: All fees for services not covered and/or paid by insurance including co-payments and deductibles will be the responsibility of the patient or responsible party at the time services are rendered. Cash, check, money orders, VISA, MasterCard, American Express, and Discover are also accepted. Care Credit is provided as a financing option.
I understand that I am responsible for any amount not paid for by my insurance:

Signature of Patient/Guardian: _____ Date: _____
(or responsible party)

I authorize Cascade Eye Center to obtain medication history electronically from my pharmacy benefit administrator:

Patient/Guardian Signature: _____ Date: _____

Revised 10/7/2013