Silverdale Eye MDs

PATIENT NAME: ______________________ SSN: ____________ Gender: ________

Birthdate: __________ Home Phone: __________ Cell: __________ ☐ Check if OK to leave a message at these phone numbers

Mailing Address: ____

How were you referred to us: ______________________ Language: __________

Employer: ____

Marital Status: ______________ Spouse Name: ______________________

Race(please circle one):
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Pacific Islander
White or Caucasian

Ethnicity(please circle one):
Hispanic or Latino
Not Hispanic or Latino

Emergency Contacts with Phone Numbers: ______________________________

GUARANTOR INFORMATION(IF PATIENT IS A MINOR):

Guarantor: ______________________ Patient's Relation: ______________

Birthdate: __________ Home Phone: __________ Daytime Phone: __________

Address with City, State, and Zip: ______________________________

Subscriber Information(if different from Patient): Please be advised that HIPAA regulations state that claims lacking any of the subscriber information will not be processed (whether the insurance is primary, or we are billing a secondary or tertiary insurance.) The information needed is listed below. If you do not provide us with this information, we will not be able to bill your claims and you will be responsible.

INSURANCES: Please present insurance card(s) to copy for billing information.

****MEDICAL**(PLEASE LIST PRIMARY and SECONDARY):

Primary Ins: ______________________ Secondary Ins: ______________________

Subscriber: ______________________ Subscriber: ______________________

Member Number: ______________________ Member Number: ______________________

Subscriber DOB: ______________________ Subscriber DOB: ______________________

HIPAA Confidential Patient Contact Person

Based upon your written consent here-in the person(s) specifically listed below is/are the only person(s) to whom information will be released other than you, the patient

Name: ______________________ Relationship: ______________________

Address: ____

Telephone: ______________________ Date of Birth: ______________________

I prefer my appointment reminders to be...

Check all that apply

☐ Phone - (with voicemail) _______________

☐ Text - (Mobile#) _______________

☐ Email - _______________