BAY EYE CARE CENTER

PATIENT DEMOGRAPHIC INFORMATION

Date _____

PATIENT INFORMATION

Last Name | Suffix | First Name | M.I.

Nickname | Previous Last Name

Social Security # | Birth Date | Age

Current Gender ☐ Male ☐ Female ☐ Gender Identity _____

Address | City

State | Zip Code | County

2nd Address | City

State | Zip Code | County

CONTACT INFORMATION

Cell Phone | Home Phone

Work Phone | Email

How would you like us to contact you for appointment reminders? ☐ Phone Call ☐ SMS (Text) ☐ Email ☐ Voice Reminders

EMERGENCY CONTACT

Emergency Contact Name | Relationship

Cell Phone | Home Phone

Race: ☐ White ☐ African American ☐ Hispanic or Latino ☐ Indian ☐ Asian ☐ Native American ☐ Other

Language: ☐ English ☐ Spanish ☐ Hindi ☐ Polish ☐ Japanese ☐ Sign Language ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Not reported

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed

PHYSICIAN / PHARMACY

Family Physician | Phone

Pharmacy | Location

REFERRAL INFORMATION

Referred By: ☐ Physician _____ ☐ Optometrist _____

☐ McLaren Bay Region ☐ Mid Michigan Medical Center ☐ West Branch Medical Center

☐ Hospital: ☐ Other:

EMPLOYMENT

Employer Name | Work Phone

Employer Address

RESPONSIBLE PARTY (if other than patient or under the age of 18)

Last Name		First Name	M.I.
Social Security #		Birth Date	Relationship
Address	City	State	Zip

HEALTH INSURANCE INFORMATION

Medical Insurance Primary	Subscriber Name	Subscriber Date of Birth
Medical Insurance Secondary	Subscriber Name	Subscriber Date of Birth

VISION INSURANCE INFORMATION

Vision Insurance Primary	Subscriber Name	Subscriber Date of Birth
Vision Insurance Secondary	Subscriber Name	Subscriber Date of Birth

TAKE ALL INSURANCE CARDS TO RECEPTIONIST TO BE SCANNED

I authorize the practice to leave messages on my answering machine/voice mail. ☐ **Yes** ☐ **No**

I authorize the release of my protected health information over the telephone or in person to the following individuals.

Name of Person	Relationship	Phone Number
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Financial assignment and agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

2. **In order to control your cost of billing, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.**

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid, it agents, or any insurance carrier I may have, any information needed to determine these benefits or benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

ALL PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THE REFRACTION FEE IF THAT IS NOT COVERED BY SAID INSURANCE

Patient / Guardian Signature:	Date:
Employee Signature:	Date: