OREGON EYE CONSULTANTS LLC

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Patient Information

Name *(as listed w/primary insurance)*			SSN
Preferred Name		Gender ☐ F ☐ M	DOB
Mailing Address	City	State	Zip
Employer	Occupation	Work Phone	
Primary phone	Type ☐ Cell ☐ Home	**OK to receive text reminders? ☐ Yes ☐ No**	
Secondary phone	Type ☐ Cell ☐ Home	**OK to leave a detailed message? ☐ Yes ☐ No**	
		E-mail: _____	
Primary Care Physician	PCP Location (City/State)		
Emergency Contact	Phone	Relationship	
Responsible Party *(if different from patient)*	DOB	SSN	Primary Number
Address	City	State	Zip
Employer	Work Phone		

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Decline to answer ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____ ☐ Decline to Answer

How did you hear about us? ☐ OEC Patient _____ ☐ Internet ☐ Insurance ☐ Facebook ☐ Dr. _____ ☐ Our Website ☐ Other_____

Insurance Information

Primary	Subscriber	DOB	ID #
Secondary	Subscriber	DOB	ID #
Tertiary	Subscriber	DOB	ID #
VISION INSURANCE Primary/Secondary	Subscriber	DOB	ID #

OR are we billing: ☐ Worker's Comp ☐ Auto Insurance ☐ Other Liability Insurance

Date of injury	Insurance Company	Claim #

I give my permission for affiliates of Oregon Eye Consultants to speak to the following individuals regarding my healthcare:

Name	Relationship	Name	Relationship

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. **Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made with our billing office in advance.**

I request that payment of authorized Medicare benefits be made either to me or to the provider named above for any services furnished me. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits for related services.

Our practice may refer you to an entity in which the referring practitioner has a financial interest. You have the right to choose any facility, diagnostic lab or practitioner. We will honor your decision to seek treatment outside our recommendation; please confirm insurance coverage for your alternate choices.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered. I have been offered the HIPAA Privacy Practices.

Date: _____ **Signature:** _____ **Printed Name:** _____