205 S. Main St., Ste. D Longmont, CO 80501 FRONT RANGE EYE PHYSICIANS P: 303-772-3611 F: 303-772-3609

PATIENT INFORMATION

Patient Name: _____ Date:____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home #: (_____)_____ Cell #:(_____)_____ Work #:(_____)_____

Date of Birth:_____/_____/_____ Social Security #:_____-_____-_____

Marital Status: (circle one) Single Married Divorced Widowed Other_____ Gender: Female Male

Preferred contact method (circle one)? Home Phone Cell Phone Call Cell Phone Text

When confirming your appointment, do you give our office permission to leave a message via text or voicemail on your cell phone (circle one)? Yes No

Email Address: _____

Who may we thank for referring you? _____

Primary Care Physician: _____ PCP Phone #:(_____)_____

INSURANCE INFORMATION

Primary Insurance Company: _____Secondary Insurance Company: _____

Name of Insured (if different from above): _____

Address:_____ City:_____ State:_____ Zip:_____

Insured's DOB:_____/_____/_____ Insured's Social Security #:_____-_____-_____

Insured's Home#:(____)_____ Insured's Cell#(____)_____ Insured's Work#(____)_____

Please read and Initial each line:

____ I authorize Front Range Eye Physicians, PC to diagnose and treat my condition. I assign directly to Front Range Eye Physicians, PC all applicable medical benefits for services rendered.

____ I understand that I am ultimately financially responsible for all approved and covered charges whether or not they are paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

____ I acknowledge receipt of the Privacy Statement from Front Range Eye Physicians, PC. Included in this acknowledgement is my understanding that audio and/or video recording of any part of my medical appointment today is strictly prohibited, unless specifically authorized by Front Range Eye Physicians, PC. I understand that this restriction is due to HIPAA privacy laws, as other patients may inadvertently be recorded as well.

____ I authorize Front Range Eye Physicians, PC to use and disclose my protected health information (PHI) for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Patient Signature_____ Date:_____/_____/_____

Parent or Guardian Signature_____ Date:_____/_____/_____

OFFICE USE ONLY: Please Initial & Date _____Checked ID _____Checked Ins _____Scanned Ins Card Rev 1/20