205 S. Main St., Ste. D Longmont, CO 80501 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: ____

Emergency Contact Name and Phone: ____

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 3/21