RIVERBEND EYECARE & OPTIQUE

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Bend, OR 97702
Business: 541.317.9747 Fax: 541.317.1818

Today's Date: _____

PATIENT INFORMATION						
Last Name		First Name			Initial	
Home Address		City		State	Zip	
Social Security #		Birth Date		Age	M	I
Home Phone		Work Phone				
Cell Phone		E-Mail				
Spouses' Name		Child's Name			Age	
Child's Name	Age	Child's Name			Age	

HOW DID YOU HEAR OF OUR OFFICE? :

OCCUPATION:	**EMPLOYER:**

INSURANCE INFORMATION		
Insurance Company Name **(Primary)**		
Subscriber Name	Social Security #	Birth Date
Insurance Company Name **(Secondary)**		
Subscriber Name	Social Security #	Birth Date

PATIENT AUTHORIZATIONS & DISCLAIMERS

I authorize Riverbend Eyecare to bill my insurance company now and for any future services received by me. I authorize Riverbend Eyecare to request and release information necessary to process my insurance claims. I authorize my insurance company to pay Riverbend Eyecare for services rendered.

I authorize Riverbend Eyecare to call my insurance company in order to provide me with information regarding my benefits. I understand that insurance companies occasionally misquote information provided to Riverbend Eyecare over the phone and th the information given to me is a patient courtesy and not a guarantee of insurance eligibility and/or payment for services Riverbend Eyecare advises that you verify the information with your insurance company and verify whether or not referrals are required by your primary care physician.

AGREEMENT TO PAY

I agree to be responsible for payment of all services provided whether or not they are paid for by an insurance compa I understand that payment for services not covered by an insurance company is due and payable at the time the services are rendered.

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient