

### Patient

**Patient:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
First Middle Last

**Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_  
 \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
City State Zip

**Email:** \_\_\_\_\_ **Gender:** Male  Female

**Social Security Number:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Spouse:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Name Relation to Patient

### Medical

**Eye Loss:** Left  Right  **Reason for Loss of Eye:** \_\_\_\_\_

**Date of First Eye Surgery:** \_\_\_\_\_ **Date of Most Recent Eye Surgery:** \_\_\_\_\_

**Eye Surgeon:** \_\_\_\_\_  
Name Location Last Visit

**Ophthalmologist:** \_\_\_\_\_  
Name Location Last Visit

**Primary Care Physician:** \_\_\_\_\_  
Name Location Last Visit

**How did you hear about us?** \_\_\_\_\_

**Do you have any medical conditions or allergies we should be aware of?** \_\_\_\_\_  
 \_\_\_\_\_

### Insurance

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**ID #:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

### Assignment & Release

Payment is due upon delivery of services. As a courtesy, we will bill your insurance for you.

I hereby authorize my insurance and government benefits be paid directly to Northwest Eye Design. I am financially responsible for any balance due and agree to pay this upon delivery of services. If the insurance company sends the checks for my services directly to me, I will immediately make the full amount payable to Northwest Eye Design for services rendered. I authorize release of any photographs taken as part of my medical record. I also authorize Northwest Eye Design to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of Responsible Party Printed Name Relationship to Patient Date