NORTHWEST eyedesign

nweyedesign.com

A personalized approach to prosthetic eye design

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

12911 120TH AVE NE C10 KIRKLAND WA 98034 | FAX 425-823-1522 | CALL/TEXT 425-823-1861