Western Slope Eye Care, PLLC

Bookcliff Vision Center — **Grand Junction**

San Juan Eye Centers — **Montrose** **Delta**

PATIENT DEMOGRAPHIC, FINANCIAL & INSURANCEINFORMATION

Patient Name____________________**Birth Date**__________ **Spouse**______________

Address__________________________**City**________________**State**_____**Zip**_____

Home Phone___________ **Other contact phone**____________ **SS#**________________

Employer________________ **Occupation**_______________ **Email**________________

Guarantor (for minors)_________________ **SS#**______________ **Birth Date**______

Address (if different than above)____

Vision Insurance Company_________________ (covers 'routine' eye exam & sometimes materials)

Medical/Health Insurance Company__________________(covers eye exam, **except refraction,** for a medical-based problem; this may include diabetes, dry eyes, infection, allergies, glaucoma, cataracts, floaters)

Insurance Plan Subscriber ________________________ **ID number**____________

May we contact you by e-mail? (for appointment recall & reminder, for providing important office or eyecare information, or for convenient online contact lens ordering) **Initial if YES** ☐

If this is your first time here, how did you find out about us?

Yellow page ☐ Insurance Plan ☐ TV ☐ Newsprint ☐ Mail ☐

Referred by____________________

If you have insurance, we may elect to bill your insurance company. If we are not a participating provider, the insurance may reimburse at a lower fee, if at all. It is your responsibility to pay deductibles, co-pays, or balances not paid by the insurance.

I authorize release of information from my exam record deemed necessary by my insurance company and assign all benefits for unpaid services to ***Western Slope Eye Care, PLLC***.
I understand that financial responsibility for my account is ultimately mine.

Also, by signing this form, I give consent to treatment for myself or to the Minor for which this information pertains. I give permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I also agree to financial responsibility for any additional tests or procedures that may be necessary for diagnosis and treatment.

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Signature of patient or legal guardian **Date**