Bellingham Family Eye Clinic

Glenn D. Green, O.D.• Riya R. Paranthan, O.D.• Denis R. Holmes, O.D.
Optometric Physicians

WELCOME TO OUR OFFICE

DATE:__________________

PATIENT'S NAME: Mr Mrs Miss Ms Dr____
(circle one) LAST FIRST MI

HOW DO YOU WISH TO BE ADDRESSED?_____________________________________

PATIENT'S DATE OF BIRTH: _____/_____/_____ SEX: M F RACE:__________________

PATIENT'S ADDRESS:____
STREET

______________________________ ________ _____________
CITY STATE ZIP

PATIENT'S HOME PHONE:_________________ CELL PHONE_________________ WORK PHONE_______________

PATIENT / PARENT SOCIAL SECURITY NUMBER____________________EMPLOYER__________________________

PATIENT'S OCCUPATION:_____________________________EMAIL____
(IF STUDENT, LIST GRADE, SCHOOL AND TEACHER)

SPOUSE / PARENT NAME:_____________________________RESPONSIBLE PARTY:_________________________
(FOR CHILDREN UNDER 18)

I CURRENTLY WEAR ❑ GLASSES ❑ CONTACTS. WHO PRESCRIBED THEM?_______________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?____

We are committed to providing you with the best possible care. If you have medical / vision insurance we are eager to help you receive your maximum allowable benefit. It is your responsibility to understand your insurance benefits (some insurance companies that we are contracted with have added a vision plan that is separate from the major medical and we may not be providers). If we are not contracted with your insurance we may file a claim as a courtesy. All unpaid balances are patient responsibility.

If you would like us to bill your insurance you must provide a copy of the insurance card.

Name of Insurance____

Name of Subscriber______________________________________ I.D. No._________________________

Date of Birth________________________ Social Security Number_______________________________

If you are not contracted with your insurance and do not submit a claim, we will offer you a cash discount. We would ask that payment be made when services are rendered. We will provide an insurance bill that you can send in to your insurance company for reimbursement.

I understand that I am responsible for payment of any charges not covered by my insurance. I authorize payment of health care benefits to this clinic. I also authorize release of any medical records necessary to process any claims.

X____
patient / guardian signature

Full payment for services, glasses and contacts is due when received. THANK YOU.