

# GRANDVILLE EYE CARE

## PERSONAL INFORMATION

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referred by \_\_\_\_\_

## RESPONSIBLE PARTY

Who is responsible for the account? (after insurance)  
Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

In the event of an emergency who should we contact?  
Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## FINANCIAL ARRANGEMENTS

For your convenience, we accept cash, check, master card or visa.  
Payment in full is expected at each appointment.

## INSURANCE INFORMATION

Do you have vision insurance Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, we will need a copy of the insurance card.

## AUTHORIZATION and RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such care to third party payers and / or health practitioners.  
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

\*\*\*Please turn over to sign HIPAA form\*\*\*