Patient Information

Name_____Age_____
Address/City/Zip_____
Date of Birth_____ Male/Female_____ Social Security #_____
Circle one: Single Married Widowed Divorced
Telephone (home) _____Telephone (work or cell)_____
Email address_____
Occupation _____ Employer _____
Employer Address/Phone_____
Name of Spouse_____ Employer_____
Spouse Employer Address/Phone_____

Complete if patient under 18 years of age:
Name of Father_____ Social Security #_____
Address/Phone_____
Name of Mother_____ Social Security #_____
Address/Phone_____

Emergency Contact (nearest relative) Name_____ Relationship_____
Address_____
Home phone_____ Work or Cell phone_____

Do you have insurance coverage? Yes No If yes, by whom are you covered?
Worker's Compensation (place of employment/address)_____
- ☐ Medicare #_____
- ☐ Medical Assistance # _____
- ☐ Other Insurance Company:_____ id#/policy# _____

group #_____ subscriber name_____ subscriber DOB:_____

Medical Authorizations:

Assignment of Benefits: I authorize my medical insurance plan to make direct payment to Chippewa Valley Eye Clinic, Chippewa Falls, S.C. for all medical or surgical services that I may have or my dependents may have while under the care of the Chippewa Valley Eye Clinic physicians.
Patient name:_____
Signature of patient or guardian:_____ _____

Financial Responsibility: I have been advised that should my insurance plan not make payment in full for the charges incurred while under the care of the Chippewa Valley Eye Clinic, Chippewa Falls, S.C., or if I am not covered by an insurance plan, I will be responsible for any unpaid balance.
Signature patient or guardian:_____

Medical Information Release: I authorize the release of any hospital or office records necessary for processing claims for the Chippewa Valley Eye Clinic, Chippewa Falls, S.C.
Signature of patient or guardian:_____ Date:_____