· CHIPPEWA VALLEY ·
EYE CLINIC
2525 COUNTY HWY I
CHIPPEWA FALLS, WI 54729

PATIENT INFORMATION

Full Name: _____ Age: _____

Address/City/Zip: _____

Date of Birth: _____ Male/Female: _____ Social Security #: _____

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Phone Number: _____ Secondary Phone Number: _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address/Phone: _____

Name of Spouse: _____ Employer: _____

Spouse Employer Address/Phone: _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE:

Name of Father: _____ Social Security #: _____

Address/Phone: _____

Name of Mother: _____ Social Security #: _____

Address/Phone: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Do you have insurance coverage? ☐ Yes ☐ No If yes, by whom? _____

Worker's Compensation (place of employment/address): _____

☐ Medicare # _____

☐ Medical Assistance # _____

☐ Other Insurance Company: _____

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 wile 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 of 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: _____