Confidential Patient History Questionnaire

Today's Date: _____

Legal
Last Name: _____

Legal
First Name: _____

Preferred
Name: _____

Middle
Initial: _____ DOB: _____ Gender: _____

SSN*: _____

*Social Security Number is needed
if we are billing insurance:

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Insurance: _____

Policy Member: _____

DOB: _____ Relationship to Patient: _____

Employer: _____

We will need a copy of your card. We will only file a claim 2 times and then it becomes your responsibility.

Account Responsible:
(Guardian/parent of the patient)

Name: _____

Relationship
to Patient: _____

Phone: _____ DOB: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____

SSN*: _____

Divorced parents: We are not a party to the divorce agreement. Therefore, the responsible party is the parent who accompanies the child to our office.

Please sign indicating that you have had the opportunity to read our Notice of Privacy Practices, authorizing the release of medical or other information necessary to process your insurance claim, and authorizing insurance benefits to be paid directly to Heart Mountain Eyecare Group. You will be responsible for non-covered services.

I have read the information above I understand and agree to it. I verify that all the information I have filled out is true and correct.

Date: _____ Signature: _____