Alaska EyeCare CENTERS

PATIENT INTAKE

Patient Legal Name:	DOB:	Date:

Your minimum exam copayment today could be: Routine $____ Medical $_____ Contact Fit $_____(if applicable)

Final charges will be determined once your exam is completed.

Please mark your method of payment: Cash: ☐ Check: ☐ Debit/Credit: ☐

PATIENT INFORMATION

Preferred Name	Gender	Age
Home Phone #	Home Address	
Cell Phone #		
Email Address	Employer/Occupation	
SSN (if ins. requires)	How did you hear about us?	

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

VISION INSURANCE	MEDICAL INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

SECONDARY INSURANCE	TERTIARY INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number

POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

PHARMACY INFORMATION

Pharmacy Name	City & Zip Code

HIPAA PRIVACY NOTICE

The HIPAA Policy was available to read during my office visit. _____(Patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide information for one individual with whom we may share your medical records.

Authorized Individual _____ **Phone Number** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ **Date** _____

09-2022