CLEVELAND EYE CLINIC
World Class Excellence in Eyecare

First Name: _____ **MI:** _____ **Last:** _____ **Previous:** _____

Address_____ **Apt#**_____

City_____**State**_____ **Zip**_____

Home_____ **Cell**_____ **Work**_____

Date of Birth_____ **SS#**_____ Gender: M F

Email Address_____ **How did you hear about us?** _____

Marital Status
◯ Married
◯ Single
◯ Divorced
◯ Widowed
◯ Domestic Partner

Language
◯ English
◯ Spanish
◯ Other: _____

Race
◯ White
◯ African American
◯ Asian
◯ American Indian
◯ Alaskan Native
◯ Native Hawaiian / Other Pacific Islander
◯ Decline

Ethnicity
◯ Hispanic/Latino
◯ Not Hispanic/Latino
◯ Decline

Reminder Preference?
◯ E-mail
◯ Mobile
◯ Home

Consent to Text?
◯ **Yes** ◯ **No**

Emergency Contact _____ **Relationship**_____ **Phone #** _____

MEDICAL INSURANCE

PRIMARY Insurance _____

Policy Holder Name _____

Member ID _____ Group # _____

Policy Holder DOB _____ Relation to Patient_____

SECONDARY Insurance _____

Policy Holder Name _____

Member ID _____ Group # _____

Policy Holder DOB _____ Relationship _____

VISION INSURANCE

Vision Insurance _____

Policy Holder Name _____

Policy Holder ID/SS # _____

Policy Holder DOB _____ Relation to Patient_____

Primary Care Doctor _____
Location _____
Phone # _____
Regular Eye Doctor _____
Location _____
Phone # _____

GUARANTOR **(Name to Whom Statements are Sent)** *If the patient is a minor or dependent, Cleveland Eye Clinic will need the information of the guarantor, or responsible party, to which statements are sent* below. Otherwise, check box if same as above. ☐

Patients relation to guarantor: _____ Guarantor Name: _____ DOB: _____

Address: _____

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Assignment of Benefits

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, Medicare and other government sponsored programs, private insurance and any other insurance plans, to the Cleveland Eye Clinic.

This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure the payment of benefits.

Signature:_____**Date**_____

Financial Arrangements

If you have medical insurance, we will help you receive your maximum allowable benefits. However, your insurance is a contract between you or your employer and the insurance company. We are not party to that contract. Plan benefits are defined by your coverage, not all services are covered by all insurance plans; therefore, as allowable you will be billed for any unpaid balances.

We invite you to ask questions relating to your insurance and payment for proposed services. Payment for services is expected at the time of treatment unless payment arrangements have been approved in advance. For your convenience we accept cash, checks, VISA, Mastercard, Discover and American Express. We also accept Care Credit if you need a longer repayment term.

Signature:_____**Date:**_____

Authorized Contact Person(s)

To allow Cleveland Eye Clinic to discuss your medical condition, treatment plan, surgery plan, appointment dates, and times, etc. with a family member or other person involved in your health care, please list their names and their relationship to you below. You are not required to list anyone.

I authorize Cleveland Eye Clinic to release my health information to the family members or other persons I have designated below:

Name:_____Relationship_____Phone:_____

Name:_____Relationship_____Phone:_____

ACKNOWLEDGEMENT OF NOTIFICATION OF PATIENT'S RIGHTS TO PRIVACY

I acknowledge that I have been notified of Cleveland Eye Clinic's Notifications of Patient's Rights to Privacy.

Name:_____MDI #_____

Signature:_____Date: _____ /_____ /_____

Signature:_____Date: _____ /_____ /_____

Signature:_____Date: _____ /_____ /_____

Check-In Initials _____

Check-Out Initials _____