IDAHO EYE and LASER CENTER

PATIENT INFORMATION		
Legal Name:	Birthdate:	
Address:		
City:	State:	Zip:
Phone:	Email:	
Social Security #:	Gender:	Marital Status:
Race: ☐ American Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ White ☐ Decline to specify	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to specify	
Preferred Language:	Employer:	
INSURANCE INFORMATION		
Primary Insurance:	Secondary Insurance:	
Policy #:	Policy #:	
Subscriber:	Subscriber:	
Relationship to subscriber:	Relationship to subscriber:	
Subscriber birthdate:	Subscriber birthdate:	

ACKNOWLEDGEMENT AND RELEASE

RELEASE OF INFORMATION: I authorize the release of information to any health professionals involved in my care for the purpose of facilitating the continuity of my medical care. I also authorize the Idaho Eye Center to share and/or receive medical information with the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

ACKNOWLEDGEMENT: By reading and signing this form I accept my rights and responsibilities as a patient and consent to the treatment and services provided by Idaho Eye Center. I authorize the release of any medical information necessary to process the bill to my insurance company and request payment of benefits to Idaho Eye and Laser Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I acknowledge that this authorization has no expiration date and is valid until revoked.

_____ _____

Signature of patient or person authorized to sign for patient Date

_____ Legal POA: Yes No

Witness (Idaho Eye staff)