BELLINGHAM eye PHYSICIANS

PATIENT INFORMATION FORM

A. Name:_____ **Social Security #** _____-_____-_____
Last First Middle

Birth Date:_____ **Marital Status:** (Check One): **S___ M___ O___** **Sex: M___ F___**

Mailing Address:_____ _____ _____ _____
Street City State Zip Code

Home Phone: (_____)_____-_____ **Cell Phone: (_____)_____-_____**

Employer: _____ **Work Phone: (_____)_____-_____**

Responsible Party: (if policyholder is different from patient)

Parent/Spouse: _____ **Social Security #**_____-_____-_____ **Birth Date:**_____

Parent/Spouse Address: _____ _____ _____ _____
Street City State Zip Code

Parent/Spouse Employer:_____ **Work Phone: (____)_____-_____**

May we contact you via email? □ yes □ no email address: _____

B. In Case of EMERGENCY:

Person To Contact (NOT RESIDING WITH YOU):_____ **Phone:(____)** _____-_____

Relationship to Patient: _____

C. What is the name of your Primary Care Physician? _____

D. Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agree to pay for all costs and expenses, including reasonable attorney fees. I hereby assign benefits to be paid directly to the doctor and authorize him to furnish information regarding my illness to my insurance company.

_____ _____
PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**