Mountain View EyeCare
Welcome To Our Office

Welcome to Mountain View EyeCare. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☒ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Cell Phone \ Text Yes ☐ No ☐

Email Address | Person Responsible for Account

Emergency Contact | Emergency Phone

Primary Care Physician | Patient Employer

Height ft in cm/m

Weight lbs kg

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ Other Race
- ☐ White
- ☐ Native American
- ☐ Caucasian
- ☐ Refuse To Specify
- ☐ Not Disclosed

Other Race

Ethnicity: ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language: ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

PRIMARY INSURANCE INFORMATION

Company

Insured's ID

SECONDARY INSURANCE INFORMATION

Company

Insured's ID

Please Read:

We ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. . All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Mountain View EyeCare. I understand that my primary insurance will be billed. I understand that billing any insurance Mountain View EyeCare is not in network with is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I understand my rights regarding my medical records. A copy of Mountain View EyeCare's Notice of Privacy Practices has been made available to me.

Signature | Date