

Welcome to our Office

Guthrie Eye Care Clinic
2114 W Noble Ave
Guthrie, OK 73044-2116
405.260.2020 fax: 405.282.8886

To help get the most convenient eye care and meet third party requirements, please fill out your form as completely as possible

PATIENT INFORMATION			
Name: <input type="checkbox"/> Mr <input type="checkbox"/> Miss _____		Today's Date: ___/___/___	
<input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr	(First)	(Middle)	(Last)
I prefer my name to go by: _____			
Social Security No. _____	Gender: ___M ___F	Date of Birth: ___/___/___	
Address: _____			
Street	City	State	Zip
Telephone: Home _____	Mobile _____	Work _____	
Email: _____			
Communication Preference: <input type="checkbox"/> E mail <input type="checkbox"/> Mail / Post card <input type="checkbox"/> Mobile			
Employment Status: <input type="checkbox"/> employed <input type="checkbox"/> self-employed <input type="checkbox"/> unemployed <input type="checkbox"/> retired <input type="checkbox"/> disabled (only required if using insurance)			
Your Employer _____		Position _____	
Employer's Address _____			
Is this visit due to a work-related injury? ___ Yes ___ No When? _____			
RESPONSIBLE PARTY INFORMATION (if other than above)			
Name _____		DOB _____	Address _____
Relationship _____		Home Phone _____	Work Phone _____
Their Employer _____		Their Position _____	
Their Work Address _____			
PATIENT'S NEXT OF KIN (if other than above)			
Name _____		DOB _____	Address _____
Relationship _____		Home Phone _____	Work Phone _____
Their Employer _____		Their Position _____	
Their Work Address _____			
THIRD PARTY PAYMENT INFORMATION (supply your card(s) to be copied)			
Name of Medical Insurance: _____		Member ID: _____	
Primary Insured Name: _____		Primary Insured DOB: _____	
Group # _____	Policy # _____		
Vision Care Plan (if applicable): _____		Member ID: _____	
Primary Insured Name: _____		Primary Insured DOB: _____	
Preferred Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Visa / MasterCard / Discover			

IN ORDER TO CONTROL YOUR BILLING COSTS AND REDUCE FEE INCREASES, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

I authorize the release of any medical information necessary to process my insurance claims. I also request payment of benefits directly to the physician when necessary. I understand I am financially responsible for any portion of the allowed amount not covered by my insurance carrier. I hereby understand all of the above and state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Signature: _____ Date: _____