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☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr _____ Today's Date:____/____/____
(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 Disclaimer: As a convenience for our patients, we use text messaging and emails to communicate basic information to our patients, including: appointment reminders, notice of office hours changes, notification for pickup of glasses/contacts orders, etc. If you would like to opt-out of electronic messaging, please inform our front desk staff.

Race: ☐American Indian ☐Asian ☐Black/African American ☐Hispanic ☐Native Hawaiian ☐ White ☐Decline to Specify

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify

Employment Status: ☐employed ☐self-employed ☐unemployed ☐retired ☐disabled (only required if using insurance)

Your Employer_____Employer's Address:_____

Position:_____ 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: ☐Cash ☐Check ☐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:_____