WELCOME TO EYECARE OF LEHI

EYE CARE FOR THE ENTIRE FAMILY - DR. ROBERT GRAY

Patient Information:

Patient Name: _____ Today's Date: _____/_____/_____
First M. Last

Street Address: _____ Sex: M ____ F ____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Preferred Contact: cell_____ home _____ work_____

Patient Birth Date: _____/_____/_____ Age: ____ Pt. SSN (optional): _____

Email: _____ Occupation: _____

Guardian if under 18: _____ Guardian Phone #: (_____) _____

How did you hear about us? _____

Primary Vision Insurance:

Insurance Co. Name: _____ Member ID/SSN: _____

Responsible Member Name: _____ Date of Birth _____/_____/_____

Employer: _____ Relationship to patient: _____

Primary Medical Insurance:

Insurance Co. Name: _____ Member ID/SSN: _____

Responsible Member Name: _____ Date of Birth _____/_____/_____

Employer: _____ Relationship to patient: _____

Marital Status (Please circle one): Widowed Divorced Married Single Other

Race (Please circle one**)**: White American Indian Pacific Islander Black/African American Alaskan Native Asian Other

Ethnicity (Please circle one**):** Hispanic or Latino Not Hispanic or Latino

I hereby give my consent for Eyecare of Lehi to use and disclose my protected health information (PHI) to carry out treatments, payment and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Eyecare of Lehi reserves the right to revise its Notice of Privacy Practices at any time. A revised NPP may be obtained by forwarding a written request to Eyecare of Lehi. With this consent, Eyecare of Lehi may call my home, leave messages, send regular mail, or e-mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls or communications pertaining to my clinical care, etc. By signing this form, I am consenting to allow Eyecare of Lehi to use and disclose my PHI to carry out TPO. I also agree to be responsible for any fees not covered by insurance and any collection charges, interest charges, or legal fees on accounts past due.

I authorize Eyecare of Lehi to use and disclose my health information to the following persons:

_____

Signature of Patient or Legal Guardian **Print Name** **Date**