YAKIMA EYE
SPECIALISTS

Patient Name Last: _____ **First:** _____ **MI:** _____ **Sex: M / F**

Date of Birth: _____/_____/_____ **SSN#:** _____ **Nickname:** _____

Mailing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Cell: (_____) _____-_____ **Home:** (_____) _____-_____ **Text reminders?** **YES☐** **NO☐**

Marital Status: _____ **Spouses Name:** _____

Email: _____

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

Emergency Contact: _____ **Phone Number:** (_____) _____-_____

Primary Language (circle one): English / Spanish / Other: _____

Referring Doctor: _____ **Phone Number:** (_____) _____-_____

Primary Medical Doctor: _____ **Phone Number:** (_____) _____-_____

IF YOU HAVE INSURANCE YOU WOULD LIKE US TO BILL YOU MUST FILL OUT THE FOLLOWING

PRIMARY INSURANCE – Plan Name: _____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

SECONDARY INSURANCE (IF APPLICABLE) Plan Name:

_____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

VISION INSURANCE (IF APPLICABLE) – Plan Name:

_____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

IF THIS IS A LABOR AND INDUSTRIES CLAIM, PLEASE COMPLETE THE FOLLOWING

Date of Injury: _____ Claim Number: _____

IF THE PATIENT IS A MINOR OR IS NOT RESPONSIBLE FOR THE BILL, PLEASE FILL OUT THE FOLLOWING:

Responsible Party: _____ SS#: _____

Phone Number: _____ Relationship: _____ Birth Date: _____

Employer: _____ Employer Phone Number: _____

Yakima Eye Specialists, PLLC is authorized to render service, medication and treatment as necessary. I also authorize any insurance benefits to be paid directly to the provider. I assume all responsibility for any unpaid balance, deductibles or denials.

PATIENT *OR* **Parent Signature:** _____ **Date:** ____/____/_____

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If Medicare or a Medicare Replacement Plan is your primary or secondary insurance, please fill out the:

Medicare Lifetime Authorization

Patient's Name and Address: _____

_____

_____

Patient's Medicare ID or
Medicare Replacement plan ID: _____

Yakima Eye Specialists, PLLC
1410 Lakeside Court #103
Yakima, WA 98902

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me. I understand that this is a lifetime authorization and will remain effective until further notice in writing from the patient. I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date:_____ Patient's Signature:_____