Welcome!

Griswold Eye Care

Patient Information

Thank you for choosing Griswold Eye Care to provide your eye care needs. Please complete this form (front & back) in ink. If you do not understand something, or have any questions, please ask us for help. We will be happy to assist you. ***(Please print)***

Name_____ **Date**_____ **Birthdate** _____**SSN**_____
First MI Last

Address_____**City**_____**State**_____**Zipcode**_____

Home Phone _____ **Cell Phone** _____ **How did you hear about us?**_____

Primary Care Physician _____**Emergency Contact** _____**Phone**_____

Primary Insurance

Person Responsible for Account _____**SSN** ____-____-____ **Birthdate**____/____/____
First MI Last

Ins. Co._____**Insurance ID.** _____**Employer** _____

Secondary Insurance

Person Responsible for Account _____**SSN** ____-____-____ **Birthdate**____/____/____
First MI Last

Ins. Co._____**Insurance ID.** _____**Employer** _____

Vision Insurance

Person Responsible for Account _____**SSN** ____-____-____ **Birthdate**____/____/____
First MI Last

Ins. Co._____**Insurance ID.** _____**Employer** _____

Authorization and Consent for Treatment

I certify that I understand this information to the best of my ability. I also understand that this information is necessary to provide me with safe and efficient care. I have answered all the questions to the best of my abilities and knowledge. Should further information become needed you have my permission to ask the respective health care providers or agency, which may release such information to you. I will notify the doctor of any changes in my health or medication (s).

Lastly, I agree to be responsible for payment for all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by the agreed dates, a $15.00 late charge will be added to my account per month.

Signature Parent or Responsible Party_____***Date*** _____

Relationship to Patient _____