



7001 Roosevelt Way NE, Seattle, Washington 98115 P 206.527.2987 F 206.526.8076 www.rooseveltvision.com

Welcome to Roosevelt Vision. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Please review all completed areas to ensure the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.  Other: \_\_\_\_\_  Male  Female

\_\_\_\_\_  
Last Name First Name MI Preferred Name

\_\_\_\_\_  
Street Address City State Zip Social Security Number

\_\_\_\_\_  
Date of Birth Employer Phone (home / work / cell) Alt. Phone (home / work / cell)

\_\_\_\_\_  
Email address Spouse/Partner or Parent name (if minor) Person responsible for account

\_\_\_\_\_  
Parent's Address (if different):

\_\_\_\_\_  
Primary Care Physician: Clinic/ Phone Number:

Primary Insurance Information

Medicare Patients Only: Secondary Insurance Information

Company: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Relationship to Insured:  Self  Spouse/Partner  Child

Relationship to Insured:  Self  Spouse/Partner  Child

Please Read: Payment for services is due at time services are rendered unless other arrangements have been made in advance. Most insurance policies pay only a portion of your total charges. Responsibility for verifying insurance coverage and eligibility rests with the patient. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Accounts 60 days old are subject to additional collection fees and interest charges of 1.5% per month. There will be a service charge on all returned checks. I understand (even if I do have insurance) that I will be financially responsible for payment of all charges incurred for services from this office. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefit either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for the services rendered.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Acknowledgement of Receipt of Privacy Policies: I acknowledge that I have received a copy of the Notice of Privacy Practices for this office.  Self  Guardian

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Update: I certify that the preceding information is current and correct.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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