PATIENT REGISTRATION

Valley Eye & Laser Center 4011 Talbot Road S. Suite 210 Renton, WA 98055 (425) 255-4250

Paul N. Joos, M.D. Peter G. Jones, M.D. Chris Monson, M.D.

If your insurance card indicates a primary care physician (PCP) or requires a referral to see a specialist, it is your responsibility to obtain and bring a referral to your appointment. If you do not bring in a referral when required, we reserve the right to reschedule your appointment.

Patient name: ______________________________ SSN: ______________________

Birthdate: ______________ Sex: M F (circle) Marital Status: S M W D Child (circle)

Address: ______________________ Apt. # City: ________________ State: ______ Zip: ______

Home Phone: (____) ____________________ Work Phone: (____) ____________________

Employer: __________________________ Occupation: __________________________

Spouse Name: ______________ Employer: ____________ Work Phone: (____) ___________

Primary Care Physician: ____________________________ Phone: (____) _____________

Emergency Contact: ____________________ Relation: ________ Phone: (____) ___________
(Not living with you)

Who may we thank for referring you to our office? __________________________________

If patient is a child, you must complete the following:

Father: ________________________ SSN: ________________ Birthdate: ___________

Address: ______________________ City: ________________ State: ______ Zip: ______

Home Phone: (____) ____________________ Work Phone: (____) ____________________

Employer: __________________________ Occupation: __________________________

Mother: ________________________ SSN: ________________ Birthdate: ___________

Address: ______________________ City: ________________ State: ______ Zip: ______

Home Phone: (____) ____________________ Work Phone: (____) ____________________

Employer: __________________________ Occupation: __________________________

CONTINUED ON OTHER SIDE

INSURANCE INFORMATION: Please fill out completely

PRIMARY MEDICAL:

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ______________

SSN or Identification Number: ________________ Group Number: ______________

Employer: __________________ Relationship to Patient: __________________

Amount of Co-Payment: $________

SECONDARY MEDICAL:

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ______________

SSN or Identification Number: ________________ Group Number: ______________

Employer: __________________ Relationship to Patient: __________________

Amount of Co-Payment: $________

IF YOU ARE COVERED UNDER DSHS / HEALTHY OPTIONS, YOU MUST PRESENT YOUR CURRENT COUPON & INSURANCE CARD TO THE RECEPTIONIST.

VISION INSURANCE:

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ______________

SSN or Identification Number: ________________ Group Number: ______________

Employer: __________________ Relationship to Patient: __________________

Amount of Co-Payment: $________

If work related injury, Please complete the following information:

Labor and Industries Claim Number: __________ or Self Insured Claim Number: ____________

Date of Injury: __________ Employer when injured: ______________ Phone: (____) __________

City where injury occurred: ________________ Cause of injury: ____________________

Valley Eye & Laser Center keeps a record of the health care services we provide to you. You may ask us to see and copy that record. Valley Eye & Laser Center will not disclose your records to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. Copies of "Patient's Rights" are available from the receptionist. The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical or vision services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made. I authorize the physician (Center) to release any information to process insurance claims. I authorize the insurance to be paid directly to the physician (Center). I also authorize you to give me reasonable and proper medical care by today's standards.

Patient/ Authorized signature: ______________________________ Date: ____________

THERE WILL BE A $20.00 CHARGE ON ALL RETURNED CHECKS