DRS. FINE, HOFFMAN & PACKER, LLC & AFFILIATES

I. Howard Fine, M.D.
Oregon Eye Surgery Center

Richard S. Hoffman, M.D.
Special Procedures

Mark Packer, M.D.
Focal Point Optical

It is important that you complete all the following:

PATIENT

Patient Name: _____ **DOB:** _____ **F** ___ **M** ___ **SSN:** _____

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

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Home Phone: _____ **Cell Phone:** _____ **E-Mail:** _____ **Spouse's Name** _____

Primary Care Physician: _____ **Spouse's Employer:** _____

PCP Location (city/state) _____ **Spouse's SSN:** _____

Emergency Contact: _____
(Different from Home Address/Phone) **(Name)** **(Phone)** **(Relationship)**

RESPONSIBLE PARTY

Name: _____ **DOB:** _____ **SSN:** _____ **Home Phone:** _____

Address: _____ **City:** _____ **STATE:** _____ **ZIP:** _____

Employer: _____ **Work Phone:** _____

HOW DID YOU HEAR ABOUT US?

___ **YELLOW PAGES** ___ **TV** ___ **RADIO** ___ **INSURANCE LIST** ___ **FRIEND** ___ **RELATIVE**
___ **NEWSPAPER** ___ **DR.** _____ ___ **OTHER**

INSURANCE INFORMATION

(Please present your insurance cards for photocopying)

MEDICAL INSURANCE:
Primary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____
Secondary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____
Tertiary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____

VISION INSURANCE:
Primary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____
Secondary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____
Tertiary: _____ **Subscriber:** _____ **DOB:** _____ **ID #:** _____

OR are we billing: ___ **Worker's Comp Date Occurred:** _____ **Ins.Co.** _____ **Claim #:** _____
___ **Auto Insurance Date Occurred:** _____ **Ins.Co.** _____ **Claim #:** _____

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. **Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made with our business office in advance.**

I request that payment of authorized Medicare benefits be made either to me or to the provider named above for any services furnished me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. I further give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to anyone answering at my home telephone number or for the leaving of that information on my home answering machine.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered.

I have been offered the HIPAA Privacy Practices.

Date: _____ **Signature:** _____
Patient Signature (Parent or Guardian if patient is a minor)

Printed Name: _____