COLORADO EYE CARE

Gary A. Jamell, M.D. | 303-781-4008 | www.coeyecare.com

PATIENT REGISTRATION FORM

NOTE: Please DO NOT email this form, instead, print it out and bring it with you to your appointment.

PATIENT DATA

Patient Name: _____ DOB (mm/dd/yyyy): _____

Phone: Cell: _____ Home: _____ Work: _____

Address: _____

Email*: _____ SSN: _____

*(*By checking here ☐ and providing your email address, you consent to contact via email: a detailed email policy is available.)*

Preferred Contact Method: ☐ Phone ☐ Email ☐ Postal Preferred Phone: ☐ Cell ☐ Home ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Widowed Preferred language: ☐ English ☐ Other

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relation: _____

INSURANCE DATA

Insured Name: _____ DOB (mm/dd/yyyy): _____

Insured SSN: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other _____ Phone: _____

Primary Insurance Carrier: _____ Additional Ins. Carriers: _____

GENDER/RACE DATA*

☐ Male ☐ Female Gender not listed _____

Race:

☐ White/Caucasian
☐ Native Hawaiian / Pacific Islander
☐ Black or African American
☐ Other _____
☐ Native American
☐ Asian
☐ Prefer not to respond

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other _____
☐ Prefer not to respond

*In order to meet "Meaningful Use" criteria as set forth by the Federal Government, we are required to obtain the following information: race, ethnicity, preferred language, gender and date of birth.

PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____ Address: _____

INSURANCE AUTHORIZATION

With my signature below, I hereby authorize all of my insurance companies to make payment directly to Colorado Eye Care. This assignment will remain in effect until revoked by me in writing. I understand that I have primary financial responsibility for all charges whether or not paid by an insurance company. I authorize the release of any medical information necessary to process these claims. Further, I acknowledge receipt of and agree to abide by Colorado Eye Care's Financial Policy.

Patient/Responsible Party Signature _____ **Date** _____

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE Colorado Eye Care to examine and treat me, or the individual for whom I am responsible. **Note:** Your eyes may be dilated during the course of an examination. If you do not feel comfortable driving after you have been dilated, please decline dilation or allow time for the effect of the dilating drops to wear off.

Patient/Responsible Party Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge I have been presented with a copy of Colorado Eye Care's Privacy Practices.

Patient/Responsible Party Signature _____ **Date** _____

MEDICARE PATIENTS

After you are seen by the doctor, Colorado Eye Care will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

Patient/Responsible Party Signature _____ **Date** _____