☐ **WATERVILLE**
☐ **PITTSFIELD**
☐ **FARMINGTON**
☐ **MONSON**

EYE CARE OF MAINE

ACCT. # _____

DR _____

APPT. _____

FIRST NAME: _____ M.I.: _____ LAST NAME: _____

PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE/HOME: _____ WORK: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ PATIENT PORTAL: EMAIL _____ TEXT ____

DATE OF BIRTH: _____ AGE: _____ SEX: M / F / OTHER MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION: _____

PARENT/SPOUSE NAME: _____ EMPLOYER: _____

EMERGENCY CONTACT; _____ PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? NAME: _____

FRIEND: _____ OPTOMETRIST: _____ MEDICAL DOCTOR: _____ OTHER: _____

REFERRING PHYSICIAN: _____

INSURANCE INFORMATION:

PLEASE PRESENT ALL OF YOUR INSURANCE CARDS AND PAYMENT INFORMATION TO THE CHECK-IN PERSON.

INSURANCE/MEDICAL RELEASE INFORMATION:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO EYE CARE OF MAINE FOR ANY SERVICES FURNISHED ME BY THESE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE: _____ DATE: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS WITH MY INSURANCE COMPANY OR FOR THE PURPOSES OF QUALITY ASSURANCE/UTILIZATION REVIEW.

SIGNATURE: _____ DATE: _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO EYE CARE OF MAINE FOR SERVICE RENDERED WHEN ASSIGNMENT IS TAKEN.

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
FAMILY / NON-RELATIVE / GUARDIAN

Patient Name: _____ Account #: _____

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. However, any actions taken prior to the date of the revocation shall not be affected by the revocation. Unless specified below, I give my permission to Eye Care of Maine to release to individual persons involved in my care all medical records and information pertinent to my care and necessary to act on my behalf. This release does not include hospitals, physicians, or other agencies that are covered on a separate release.

Information may be released to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Do ***not*** release information pertaining to: _____

My consent to release my records is effective until _____ .
(Date not to exceed 30 months from date of consent.)

_____ _____ _____
(Signature of Patient or Legal Representative) (Relationship) (Date)

A copy of this form is available to the signer upon request.