iWellness:

Patient Information Form

Appointment Time:

First Name | **Mid. Initial** | **Last Name** | **Preferred Name** | **Birth Date**

Street Address | **City** | **State** | **Zip**

Home Phone | **Cell Phone** | **Email Address**

Preferred Contact Method ☐ Home ☐ Cell ☐ Text ☐ Email

Person Responsible For Charges (if not patient) | **Relationship to Patient** | **Phone Number**

Race highlight your answer

Native American/Alaska Native Asian Black/African American

Native Hawaiian/Pacific Islander White Other Race

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Preferred Language

Please read and initial each item that applies.

___ I request payment of insurance benefits, including Medicare benefits, be made on my behalf to Uptown Eye Care for any services rendered.

___ Insurance benefits quoted to the patient and/or provider's office are **NOT A GUARANTEE OF COVERAGE. ACTUAL BENEFITS ARE DETERMINED WHEN THE CLAIM IS PROCESSED**

I understand that I am responsible for any remaining balance.

___ I have chosen to pay the discounted Same-Day-Pay rate for services received.

Signature of patient/authorized person_____Date_____

There are times when a friend or family member may contact our office requesting information regarding you, the patient. Is there anyone authorized to receive your medical information? For example: parents, legal guardians, spouse, children, or other family members.

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