PREMIER EYE CARE
OF EASTERN IDAHO
MEDICAL • SURGICAL • OPTICAL

PATIENT INFORMATION

Matthew P. Traynor, MD
Kyle G. Thompson, MD
Jason G. Hooton, MD

Date_____ Gender ☐ Male ☐ Female
Patient Name_____
Address_____
City_____ST_____Zip_____
Phone Numbers: Home_____
Work _____ Cell _____
Date of Birth_____
SSN_____
Email _____
May we contact you by text and email? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION (PARENT NAME IF MINOR)
Name_____
Relationship_____
Phone_____ Alt. Phone_____

Referred by_____
I allow my medical information to be released to (names):
_____
_____

How did you hear about us? _____

PRIMARY INSURANCE COVERAGE
Insurance Co_____
Policy Holder's Name_____
Date of Birth_____
Member ID#_____
Group #_____

SECONDARY INSURANCE COVERAGE
Insurance Co_____
Policy Holder's Name_____
Date of Birth_____
Member ID#_____
Group #_____

Marital Status:
__ Single __ Married __ Widowed __ Divorced __ Separated

Preferred Pharmacy: _____
Pharmacy City / ST: _____

Race/Ethnicity(now required to ask)_____
Profession _____ Employer_____
Preferred language_____ Preferred mode of communication ☐ Phone ☐ Email ☐ Mail

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S)

MEDICARE/INSURANCE AUTHORIZATION: By signing below, I attest that the above information is true and correct. I certify that I (or my dependent) have/has insurance coverage as stated above and request that payment of authorized benefits from my insurance company be made directly to Premier Eye Care of Eastern Idaho PLLC to be applied to my account for services rendered. I further understand that Premier Eye Care of Eastern Idaho PLLC will bill my insurance as a courtesy to me, and that I am ultimately financially responsible. I have read and understand that regardless of insurance coverage, I am responsible for all copayment, coinsurance, deductible, refraction, non-covered services, or any other services denied by my medical insurance because of benefit or plan coverage limitations. I hereby authorize any holder of my medical information to release said information to the Health Care Financing Administration, my insurance company, other medical providers or financial institutions and/or Premier Eye Care of Eastern Idaho PLLC for the purposes of treatment, payment or health care operations. I understand that unless previous arrangements have been made that I am expected to pay all estimated patient amounts at the time of the visit.

Signature_____ Date_____

Effective January 1, 2016: Premier Eye Care of Eastern Idaho has a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, there will be a charge of $50.