Icare Optical

1017 12th Ave. S, Nampa, ID 83651 | Ph: 208-466-5600 | Fax: 208-461-0420

PATIENT INFORMATION **PLEASE PRINT**

Last Name: Date of Birth (MM/DD/YYYY): ____/ ____/ _____

First Name: MI: Sex: Male: Female:

PHYSICAL Address: Marital Status: Single/Married/Divorced/Sep/Widowed

City: Social Security #:

State: ZIP: Email Address:

Home PH#: Preferred Pharmacy:

Cell PH#: Location:

Referred to Clinic by: Doctor/Insurance Plan/Hospital/Website
Family/Friend/Close to home or work/Phone Book/Other

Name of Employer:

Occupation:

RESPONSIBLE/BILLING PARTY:

Full Name:

Relationship to Patient:

Date of Birth (MM/DD/YYYY): ____/ ____/ _____

*BILLING Address:

City:

State: ZIP:

Home PH#:

Cell PH#:

EMERGENCY CONTACT INFO:

Last Name:

First Name: MI:

Relationship to Patient

PHYSICAL Address:

City:

State: ZIP:

Home PH#:

Cell PH#:

INSURANCE INFO: (present card ay check in – this will be scanned into your file)

Subscriber's Name: Policy / ID #:

Relationship to Patient: Self/Spouse/Child/Other Group #:

Address (if different): Insurance PH#:

City: Co-Pay $

State: ZIP: Subscriber's S.S. #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Icare Optical or insurance company to release any information required to process my claim.

X _____ **Date:** 02/13/2018

Patient / Guardian Signature