VISION QUEST MEDICAL CENTER

5680 W. GAGE STREET, BOISE, ID 83706
(208) 377-3937
3025 W. CHERRY LN., SUITE 207, MERIDIAN, ID 83642
208-898-1614

PATIENT INFORMATION

PATIENT'S FULL NAME:_____ DATE OF BIRTH:_____
FIRST MIDDLE LAST MM/DD/YY

WHAT DO YOU LIKE TO BE CALLED? (NICKNAME):_____

NAME OF SPOUSE (PARENT IF MINOR): _____

ADDRESS: _____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE: _____

MARITAL STATUS: M / S / D / W SEX: M / F SOCIAL SECURITY # :_____

EMAIL: _____

I PREFER APPOINTMENT REMINDERS BY: PHONE / TEXT / EMAIL

PATIENT'S EMPLOYER:_____ PHONE:_____
ADDRESS:_____ POSITION:_____
EMPLOYER OF SPOUSE OR PARENT:_____ PHONE:_____
ADDRESS:_____ POSITION:_____

EMERGENCY CONTACT: _____ PHONE:_____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE

ALL CHARGES ARE THE PATIENT'S RESPONSIBILITY, HOWEVER, AS A COURTESY, WE WILL BILL YOUR INSURANCE CO
UNPAID PATIENT DUE ITEMS OVER 60 DAYS WILL BE CHARGED 18% INTEREST PER YEAR
PLEASE PRESENT YOUR INSURANCE CARDS AND PHOTO ID SO WE MAY MAKE A COPY

IS ANY PART OF YOUR EYE EXAMINATION COVERED BY INSURANCE? (PLEASE CIRCLE ONE) YES NO

PRIMARY CARRIER:_____ ID NUMBER:_____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH REQUIRED:_____

SECONDARY CARRIER:_____ ID NUMBER:_____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH REQUIRED:_____

FAMILY MEDICAL DOCTOR:_____ PHONE:_____

INDUSTRIAL ACCIDENT

EMPLOYER AT TIME OF INJURY:_____

ADDRESS:_____

DATE OF INJURY:_____ DATE INJURY REPORTED:_____ CLAIM # :_____

STATE WHERE INJURY OCCURRED:_____ COUNTY WHERE INJURY OCCURRED:_____

INDUSTRIAL INSURANCE CARRIER:_____

ADDRESS:_____

BRIEF DESCRIPTION OF ACCIDENT:_____

_____

_____

INSURANCE AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PAYMENT OF CLAIMS. THIS AUTHORIZATION ALSO PERMITS THE RELEASE OF INFORMATION BY HEALTH CARE FINANCE ADMINSTRATION (HCFA), ITS INTERMEDIARIES OR CARRIERS, ON ANY UNASSIGNED MEDICARE CLAIMS FOR SERVICES RENDERED FOR THIS PROVIDER. I ALSO AUTHORIZE PAYMENTS UNDER MY INSURANCE POLICY(IES) TO BE MADE DIRECTLY TO THE PROVIDERS, JACOB MONG, D.O., STEPHEN REINSCHMIDT, O.D. AND GARY R. PABALIS, O.D. (DBA VISION QUEST MEDICAL) FOR ANY SERVICES RENDERED TO ME. I FURTHER PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

_____ _____
SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY) DATE

REVISED 1/23/18