Northwest Eye Center, P.C.

Melinda C. O'Rourke, M.D.
Eye Physician & Surgeon
4855 Ward Rd. #500
Wheat Ridge, CO 80033
303-467-0500 Fax 303-467-0502
www.northwest-eye.com

PATIENT INFORMATION SHEET

Date:________________________

☐ Mr. ☐ Mrs. ☐ Ms.

Patient Name:____
Last First Middle

Address:____
Street City State Zip

_____/_____/_____ Date of Birth
______________________ Marital Status
☐ Male / ☐ Female Sex
_________/_______/_________ Social Security Number

____________________ Home Phone
____________________ Cell Phone
______________________________ E-mail Address

______________________________ Responsible Party
____________________ Phone Number
____________________ Relation to Patient

Employer:____________________________________ Work Phone:______________________________

Address:____
Street City State Zip

Referred by:_____________________________ ☐Postcard ☐Newspaper ☐Website ☐Magazine ☐Other______________________

INSURANCE

Vision Insurance_____________________ Medical Insurance_____________________ Secondary Insurance_____________________

ID/Member #_____________________ ID/Member #_____________________ ID/Member #_____________________

Group #_____________________ Group #_____________________ Group #_____________________

Insured DOB_____________________ Insured DOB_____________________ Insured DOB_____________________

Insured SS #_____________________ Insured SS #_____________________ Insured SS #_____________________

Relationship to Patient______________ Relationship to Patient______________ Relationship to Patient______________

PCP:____________________________________ PCP Phone:______________________________

PCP Address:____
Street City State Zip

Student: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

I authorize the release of any medical information necessary to process all claims and payments of medical benefit directly to my physician.

I am aware of the availability of the protected health information for the Northwest Eye Center and their office policies for handling all such information and indicate that I was notified of the copy available in the office.

I understand that providing insurance information does not constitute payment from my insurance company. Any charges not paid by insurance will be patient responsibility.

Signature:____ **Date:**______________________