«ApptTime»

Welcome to Murray, Murray, and Groves

Thank you for choosing us for you eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Title *(if applicable)* Gender*(M or F)* Patient Marital Status

First Name MI Last Name Date of Birth Social Security Number

Mailing Address City State Zip Cell Phone

Home Phone Work Phone Spouse or Parent(s) Name(s)

Emergency Contact Name & Phone Number Preferred Pharmacy Name Pharmacy location and phone #

Person Responsible for Account Responsible Party SS#& Date of Birth

How would you prefer to be contacted about future appointments and prescription ready reminders?

- ☐ Home Phone ☐ Work Phone ☐ Cell Phone
- ☐ Text ☐ Email: ______________________

Vision Insurance Information

Company: ______________ ID # ______________ Group #: ______________

Subscriber's Name: ______________ Subscriber's DOB: ______________

Subscriber's Employer: ______________ Patient Relationship to Insured: «Ins_1_Relationship»

Self, Spouse, Child, Other

Medical Insurance Information

Company: ______________ #: ______________ Group #: ______________

Subscriber's Name: ______________ Subscriber's DOB: ______________

Subscriber's Employer: ______________ Patient Relationship to Insured: ______________

Financial Responsibility-By signing this statement I agree that I have reviewed Murray, Murray, & Groves' Financial Agreement, Version VI, and agree to all of the terms listed.

Authorization to receive funds from insurance companies- I authorize Murray, Murray, & Groves to receive payment on my behalf from my insurance company. I understand that I am responsible for all charges, regardless of insurance coverage. Benefits quoted are not a guarantee of payment and I will be responsible for the balance.

Authorization to Release Medical Information- I authorize Murray, Murray, & Groves to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Private Health Information-My signature below acknowledges that I was provided the opportunity to receive/review a copy Murray, Murray, & Groves' Privacy Policy Notice.

Authorization to perform medical procedures- I authorize Murray, Murray, & Groves' to perform medical procedures on me related to my medical exam and treatment.

Patient/Guardian Signature ______________________ Date ______________

A copy of this form will be transferred to an electronic format and will be considered as valid as the original.