

## Adult Registration Form

Eastside Family Vision Care 12040 98th Ave. NE, Ste. 104 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2147  
www.eastsidefamilyvisioncare.com efvcare@yahoo.com  
Neena Gabrielle, O.D., FCOVD

Name (Last, First) \_\_\_\_\_ Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Other family members seen in our office:

Who referred you to our office today?

Name: \_\_\_\_\_  Physician  OT  PT  SLP  Teacher  Friend/Family

Other:  Insurance  Web Search  Advertisement (type) \_\_\_\_\_  Other \_\_\_\_\_

If you were referred by a medical provider, please provide the following information:

Name of Clinic \_\_\_\_\_

Specialty of Medical Provider \_\_\_\_\_

Would you like us to send summaries of your evaluations to your referring medical provider? Yes  No

Primary Care Physician Information

Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Would you like us to send summaries of your evaluations to your primary care physician? Yes  No

Emergency Contact Information

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby give Eastside Family Vision Care permission for evaluation and treatment of myself. I hereby authorize the release of any medical or other information necessary to process insurance claims when needed. I also authorize payment directly to the doctor for any benefits available as a non-contract provider under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances. I understand that Dr. Neena Gabrielle is a non-contract provider for all insurance plans and the amount due for the visit is my responsibility. In cases where EFVC can bill my insurance as a non-contract provider, I understand that I am responsible for the balance of the bill; otherwise I am responsible for all other fees at the time of service. I understand that it is my responsibility to keep track of amounts needed to reach my deductible (if applicable). I understand that it is my responsibility to obtain any referrals from my PCP as outlined by my insurance policy.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Initials

\_\_\_\_\_  
Date