

Eye's on Commerce

Charles A Wardle OD
1426 Commerce Ave. Longview, WA 98632
360-423-7650

Patient Information

Completion of this information in its entirety is required at time of visit

Name _____ SSN _____ - _____ - _____ Gender **M / F**
 _____ Last _____ First _____ M.I. _____ Birthdate: _____ Age _____
 Email: _____
 Address _____ Home Phone _____
 _____ Street _____ City _____ State _____ Zip _____ Cell Phone _____
 Employer _____ Occupation _____
 Employer Address _____ Work Phone _____
 _____ Street _____ City _____ State _____ Zip _____
 Spouse/Parent _____ Social Security # _____ **Birth date _____
 Spouse/Parent Address (if different from patient) _____
 _____ Street _____ City _____ State _____ Zip _____
 Spouse/Parent Employer _____ Spouse/Parent work phone _____

In case of EMERGENCY:

Contact (other than spouse) _____ Phone Number _____

Referred By: Dr. _____ Friend _____ Other _____

**** Your social security number is required information on this form. Until payment by your insurance company we are in fact issuing you credit and credit cannot be offered without a social security number. If no payment is received by your insurance and subsequently you, this account would be forwarded to collections. Collection agencies are unable to make reports and obtain information from the credit bureaus without this information. This is not a HIPPA issue as it dose not relate to the medical treatment being provided. All information provided to the clinic is kept in strictest confidence as mandated by state and federal laws.**

Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits. I understand that the honest and complete answers to each question stated are important to the provision of my care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on this form I should ask the doctor or office staff for assistance.

Signature _____ Date _____