



4070 Chicago Dr. Grandville, MI 49418

Phone: 616 531-3336

Fax: 616 988-4786

**WELCOME TO GRANDVILLE OPTICAL
PERSONAL INFORMATION**

Date: _____ Birthdate: _____ Male/Female: _____

Legal Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ Employer Name: _____

SS #: _____ Occupation: _____

E-mail: _____ Referred by: _____

RESPONSIBLE PARTY-INSURANCE POLICYHOLDER

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Employer Name: _____

Relationship to Patient: _____ Referred by: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

CONSENT TO CALL -MUST BE FILLED OUT COMPLETELY

May we call you at home? Yes _____ No _____

May we call you at work? Yes _____ No _____

May we call you on your cell phone? Yes _____ No _____

Do you authorize us to leave messages regarding test results with a family member(s)? If so, whom: (List names) _____

Do you authorize appointment reminder calls to be left on your home answering machine or with a family member(s)? If so, whom? (List names) _____



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INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Name of Insured: _____	Name of Insured: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insured's birthdate: _____	Insured's birthdate: _____
Insured's S.S. #: _____	Insured's S.S. #: _____
Insured's Employer: _____	Insured's Employer: _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____
Contract # _____	Contract # _____

FINANCIAL ARRANGEMENTS

For your convenience we offer the following methods of payment: Cash, Check, MasterCard, Visa and Discover. Payment in full is expected at each appointment unless arrangements have been made with our billing department. In accordance with all HMO's your co-pay is expected at the time of service.

AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing I authorize Grandville Optical to use and/or disclose PHI about my dependent or me to carry out treatment, payment and health care operations (YPO). (The notice of Privacy Practices provided by Grandville Optical describes such uses and disclosures more completely.)

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor _____
Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at any time, please ask – we are always happy to help.

Patient's Annual Review of information _____ / _____ / _____ / _____
Initial Date