Grandville Optical

4070 Chicago Dr. SW
Phone: 616 531-3336 Grandville, MI 49418 Fax: 616 988-4786
www.grandvilleoptical.com

WELCOME TO GRANDVILLE OPTICAL
PERSONAL INFORMATION

Date: _____ Name: _____

Birthday: _____ Male/Female: _____

Address: _____
City State Zip

Home Phone _____ Work Phone: _____ Cell Phone: _____
(do we have permission to text you?) ___ Yes ___ No

Email address: _____
(do we have permission to email you?) ___ Yes ___ No SS #: _____

Employer Name: _____ Occupation: _____

RESPONSIBLE PARTY - INSURANCE / POLICY HOLDER

Name: _____ Birthdate: _____

Address: _____
City State Zip

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer Name: _____ Relationship to Patient: _____

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 ___ N
May we call you on your cell phone? ___ Yes ___ No
Do you authorize us to leave messages regarding test results with 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) _____

HOW DID YOU HEAR ABOUT US?

Facebook ____ Google ____ Yellow Pages ____ Living Social ____ Groupon ____

Drive by/Sandwich board sale signs ____ Flyer in mail ____ Radio ____

Referred by: _____ Community Expo _____

INSURANCE INFORMATION

Primary Insurance:

Name of Insured:

Relationship to Patient

Insured's S.S. #:

Insured's Employer:

Insurance Company:

Group #:

Contract #:

Secondary Insurance:

Name of Insured:

Relationship to Patient

Insured's S.S. #:

Insured's Employer:

Insurance Company:

Group #:

Contract #:

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment: Cash, Check, MasterCard, Visa Discover. **We also offer interest-free options through CARE CREDIT. Check our website at www.grandvilleoptical.com and click on the link for a Care Credit Application.** 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 & 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 of 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:
_____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ /

lo

_____ /