The Bixby EYE Center

6807 N. Knoxville Ave. Peoria, IL 61614

Office Phone (309) 692-0000

Welcome Sheet

(PLEASE PRINT CLEARLY)

Today's Date ___/___/___ Primary Care Physician:_____

PATIENT INFORMATION:

Patient's Last Name	First	Middle	☐ Mr. ☐ Dr/Rev ☐ Mrs. ☐ Ms.	Marital Status (circle one) Single / Mar / Div/ Wid	Spouse's Name

Is this your legal name? ☐ Yes ☐No	If not, what is your legal name?	(Former Name)	Birth Date ___/___/___	Age	Sex ☐Male ☐ Female

Street Address	City	State	Zip	Social Security #	Home Phone ( )

Occupation	Employer / If Student, Name of School & Grade	Employer Phone ( )

Email address:	Emergency contact:	Emergency contact phone: ( )

Who may we thank for referring you to our office? ☐ Dr._____ ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to Home Work ☐ Yellow Pages ☐Other _____

Other Family Members Seen Here

PAYMENT INFORMATION: **PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST**

Is this patient covered by vision insurance? ☐ Yes ☐ No

Primary Insurance	Insured's Name	Insured's S.S. #	Insured's Birth Date ____/____/____

Insured's Employer	Group #	Policy #	Patient's Relationship to Insured ☐ Self ☐Spouse ☐ Child ☐Other

Secondary Insurance (if applicable)	Insured's Name	Insured's S.S.#	Insured's Birth Date ____/____/____

Insured's Employer	Group #	Policy #	Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other

I authorize The Bixby Eye Center to submit my insurance on my behalf and to release any information required to process my claim. I authorize my insurance benefits to be paid to The Bixby Eye Center. I understand that I am financially responsible for any balance not paid by insurance. Should my account become past due, I shall be liable and agree to pay any collection agency fees (not to exceed 33.3%),reasonable attorney's fees, and court costs.

X

PATIENT/GUARDIAN SIGNATURE DATE

We would like to welcome you to our eye center. If you have any additional questions or comments, Dr. Bixby will be happy to discuss them with you.

Eye Health History

Please indicate any family hisory (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	You	Family	Relationship to you
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Lazy Eye			
Macular Degeneration			
Retinal Detachement			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other			