GENSTLER EYE CENTER

Darrell E. Genstler, MD
Benjamin M Jager, OD
Kent D. Reynolds, OD
2700 14th Ave. SE
Albany, OR 97322
(541) 928-1667

PATIENT INFORMATION (Please Print)

PATIENT NAME: _____
Last First Middle

SOCIAL SECURITY:_____ BIRTH DATE:_____AGE:_____

☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED

ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____

HOME PHONE:_(_____)_____ CELL PHONE:_(_____)_____

Alternate Phone:_(_____)_____ Name / Relation:_____

☐ OK to leave message on ☐ Home Ph. ☐ Cell Ph. EMAIL:_____

RACE:
☐ White ☐ American Indian / Alaska Native
☐ Black ☐ Hawaiian Native / Pacific Islander
☐ Asian ☐ Unknown ☐ Refused

LANGUAGE:
☐ English ☐ Spanish ☐ Other:_____

ETHNICITY:
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused ☐ Unknown

CONTACT Preference:
☐ Home Phone ☐ Cell Phone

INSURANCE INFORMATION (Medicare Patients only)

Please fill in you Medicare number and any other insurance policy numbers.

MEDICARE NUMBER:_____

MEDICARE SUPPLEMENT:
☐ AARP ☐ Aetna ☐ Bankers Life ☐ BCBS
☐ CIGNA ☐ Equitable Life ☐ GEHA ☐ IHN / DMAP
☐ LifeWise ☐ MODA ☐ United Healthcare ☐ TriCare for Life
☐ _____

→ POLICY NUMBER:_____

MEDICARE ADVANTAGE INSURANCE
☐ HealthNet Medicare Advantage
☐ MODA Medicare Advantage
☐ Providence Medicare Extra
☐ Samaritan Advantage
☐ Regence Medicare
☐ United Healthcare Medicare Complete
☐ Other:_____

IDENTIFICATION #	GROUP # or POLICY #	PRIMARY CARE PHYSICIAN	CoPay

ACKNOWLEDGEMENT OF PRIVACY NOTICE: I, the undersigned, hereby acknowledge being given the opportunity to review the joint Notice of Privacy Practices. I understand I may request a copy at any time.

LIFETIME AUTHORIZATION: I request that insurance payments be made either to me or to Genstler Eye Center, The Eye Surgery Center, or The EyeWear Pavilion for all services furnished to me from the date below until revoked or rescinded. I authorize the release of any information needed to process my insurance claims. I further permit a copy of this authorization to be used in place of the original.

PATIENT'S SIGNATURE:_____DATE:_____