CLEARVIEW Eye & Laser, PLLC

Thomas G. Mulligan, MD
Marcus A. Meyer, MD, FACS
Aaron P. Weingeist, MD
Keshia Casimir, OD

Patient's Name_____ ☐ Male ☐ Female
First Middle Last

Address_____ Home Phone (____)_____
Cell Phone (____)_____

City_____ State_____ Zip_____ Work Phone (____)_____

Social Security Number_____ Date of Birth____/____/____

Employer_____ Occupation_____

Marital Status_____ Ethnicity/Race_____ Language_____

Email Address_____

Name of Emergency Contact (not at same address)_____ Relationship_____

Home Phone (____)_____ Cell Phone(____)_____ Work Phone(____)_____

WHO REFERRED YOU TO THIS OFFICE?_____

PRIMARY CARE PHYSICIAN_____ Phone Number(____)_____

INSURANCE INFORMATION

Primary Medical Insurance_____
(Please provide card to receptionist)
Policy Holder/Subscriber_____ Date of Birth____/____/____

Secondary Medical Insurance_____
(Please provide card to receptionist)
Policy Holder/Subscriber_____ Date of Birth____/____/____

Vision Insurance Carrier_____
Policy Holder/Subscriber_____ Date of Birth____/____/____
Policy Holder/Subscriber Number_____ Group Number_____

ACCOUNT GUARANTOR, IF NOT PATIENT

Name of person responsible for account_____ Relationship_____
Address_____ City_____ State_____ Zip_____
Home Phone (____)_____ Work Phone (____)_____
Employer_____ Occupation_____
Employer Address_____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any copayment or balance due. I also authorize the doctor or insurance company to release my information required for this claim.

Signed_____ Date____/____/____

Comprehensive Eye Care & Surgery
ClearviewSeattle.com

West Seattle
7520 35th Ave SW | Seattle, WA 98126
p: 206.937.9600 | f: 206.937.4088

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14212 Ambaum Blvd SW #302 | Burien, WA 98166
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