Patient Information

Name ____ Birth date__________________
First MI Last
Street Address ____
City ____________________________ State ___________ Zip Code _______________
Home phone# _______________ Work# ______________ Mobile#_________________
E-mail Address _______________________________Gender ____ Male ____ Female
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Other
Employer /School ____________________________ Occupation __________________
Emergency contact _________________________ Phone # ________________________
Name of person responsible for this account (if patient is a minor)?
____
Relationship to patient ___________________ Phone # ____________________________
Address, if different ____
Employer _______________________________Work # ____________________________
Whom may we thank for referring you to us? ____________________________________

Insurance Information

<u>Please present insurance card and valid ID</u>

Name of Insured ________________________Relationship to patient _________________
DOB ________________ Last 4 of SS# __________ Insurance Co. ____________________
Subscriber ID# __________________________________
DO YOU HAVE ADDITIONAL INSURANCE? No ____ Yes ____
Name of insured ________________________ Relationship to patient ________________
DOB________________ Last 4 of SS# __________ Insurance Co. ____________________
Subscriber ID # __________________________________

<u>NOTICE OF INSURANCE RESPONSIBILITY</u> - Please read carefully

Please be prepared to pay any copays on same day of service Please inform front desk if you are unable to pay. We do not accept personal checks

We are happy to file a claim and accept payment from your insurance company. However, there is no guarantee of payment from your carrier, even though we may have verified your coverage. You, the insured are ultimately responsible for the fees incurred for your vision care. Please understand that should any of the following occur, you will be held responsible for the entire amount due :

1. Payment has not been received within 45 days of filed claim.
2. Payment is denied by the insurance company.
3. A balance remains after the insurance payment.
4. Incorrect or invalid insurance information provided to us.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I I have read the insurance responsibility statement on this form and agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____
Signature of Patient (or Parent if a minor) DATE