PATIENT INFORMATION

Today's Date ___/___/_____

Last Name_____First _____M.I. _____

Address_____

City _____State _____ Zip _____

Home Phone ( )_____Alternate Phone ( )_____

Email:_____Marital Status: Single / Married / Other

Date of Birth ___/___/_____ Last eye exam_____ Last medical exam_____

Occupation _____ Employer _____

Do you have the following medical insurance? AETNA/ UNITED HEATHCARE/ BLUE CROSS

If yes, who is the primary insured on this plan? SELF / SPOUSE / PARENT / OTHER

If not yourself: Name of primary insured _____their Date of Birth ___/___/___

Does your plan need a referral to see a specialist? YES / NO

Name of your primary care physician_____Dr's phone #_____

Your vision plan (if any): EYEMED /

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HIPPA / ACKNOWLEDGEMENT OF RECEIPT

This is to notify you that any information you provide us and any information created in the course of providing services to you will only be disclosed or used for the purposes of treatment and care and to conduct healthcare operations in our office. I acknowledge that I have been offered and/or given a copy of this office's Notice of Privacy Practices.

Patient (or parent/guardian) signature_____Date_____

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SIGNATURE ON FILE / RELEASE OF INFO / ASSIGNMENT OF BENEFITS

I authorize the release of the above information to my insurance carrier(s) in order to determine the benefits payable for services rendered. I authorize the doctors in this office to act on my behalf in obtaining payment from my insurance company and that these benefits be made payable to them. *I understand that I am responsible for any co-pays, deductibles that have not yet been met, and charges not covered by my insurance.* This serves as a lifetime signature on file form solely for the purposes stated above.

Patient (or parent/guardian) signature _____Date _____

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NOTE: If we do not accept your insurance, you are responsible for full payment for services provided by this office. *Professional service fees are not refundable.* We recommend you check with your insurance carrier prior to your eye exam to determine if they will reimburse you for out of network expenses.