

PATIENT INFORMATION FORM

Patient's LEGAL name (First, MI, Last) _____

How would you like to be addressed (Mrs., Mr., first name, other _____)

Address _____ Apt # _____

City _____ State _____ Zip _____

Preferred phone (Home, Cell, Work) _____

Secondary phone (Home, Cell, Work) _____

Email address: _____

Note: All patient information is kept strictly confidential. We are making greater use of email to communicate with our patients.

Birth date (mth/day/yr) _____ last 4 of Social Security # _____

Place of work _____ Occupation _____

Medical Insurance _____ ID# _____

Vision Insurance _____ ID# _____

Insured Person responsible for this account? Self _____ Other _____ (complete below)

Name of Subscriber _____ Employer _____

Address (If different from above) _____

Insurance ID# _____ Birth date _____ Last 4 SS# _____

How did you find us? family/friend, internet, insurance, facebook, _____

PAYMENT POLICY: PLEASE READ CAREFULLY!

1. For your convenience, we will bill your primary insurance company. It is your responsibility to know your insurance benefits prior to your appointment and provide us your insurance information before the exam.
2. Secondary insurance benefits will NOT be considered unless secondary to Medicare. As a convenience we will bill your secondary for you and reimburse if any overpayment received. Information must be provided at the time of your visit.
3. Once the insurance has been billed, changes to that billing CANNOT be made, and any amounts due will be your responsibility.
4. If a referral is required by your primary doctor, it is your responsibility to obtain the referral prior to being examined by our doctor.
5. Your copay amount and overage on glasses or contacts are due at the time service is rendered or materials ordered.
6. You will be charged \$50 for appointments cancelled within 48 hours or missed appointments.
7. Any unpaid balance on your account that you owe will be assessed a fee of \$20.00 per month starting 30 days after being mailed your first statement.

Assignment and release: I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information for this and all claims from this office. I authorize my insurance benefits be paid to the physician.

Signature/Parent of minor: _____

Print Name: _____ DATE: _____