PATIENT INFORMATION

PATINET NAME_____

_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMAIL_____

SEX M F AGE_____
BIRTHDATE_____

MARRIED WIDOWED SINGLE MINOR

SEPERATED DIVORCED

SOCIAL SECURITY #_____

OCCUPATION_____

PATIENT
EMPLOYER/SCHOOL_____

SPOUSE OR PARENT (IF MINOR) _____

BIRTHDATE_____ Social Security#_____

PHONE NUMBERS

HOME ( ) _____

CELL ( ) _____

BEST PLACE TO REACH YOU_____

CONTACT LENS PATIENTS

Contact lenses are considered a medical device, therefore, the fit of the lens, health of your eye and prescription must be evaluated yearly. Additional tests and measurements are performed during your eye exam. Fees for this service are determined by the type of contact, prescription and whether this is a new or existing exam .I understand and agree to this service.

_____

INITIAL DATE

INSURANCE

NAME OF
SUBSCRIBER_____

RELATIONSHIP TO PATIENT_____

BIRTHDATE_____

SOCIAL SECURITY #_____

NAME OF VISION
COVERAGE_____

ID#_____ GROUP#_____

NAME OF MEDIAL
COVERAGE_____

ID#_____ GROUP#_____

INSURANCE AUTHORIZATION AND RELEASE

I certify that I have coverage and assign directly to The Eye Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Eye Group may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

MEDICARE PATIENTS

I understand that Medicare DOES NOT cover a refraction and agree to pay for this service.

I agree and have been informed of the HIPPA Notice of Privacy Rights.

_____

Signature of Patient, Parent, Guardian, or Legal Representative

_____

Printed Name DATE