Family EyeCare Center -- Welcome to Our Office!

PERSONAL INFORMATION

NAME (LAST)	(FIRST)	(MIDDLE)	NICKNAME	DATE OF BIRTH

SOCIAL SECURITY	HOME ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE #

AGE	GENDER	EMPLOYER NAME	WORK PHONE #

MARITAL STATUS	EMPLOYER ADDRESS	CITY, STATE, ZIP CODE	CELL PHONE #

DATE OF LAST EYE EXAM	PREVIOUS EYE DOCTOR	☐ OK TO TEXT

DATE OF LAST MEDICAL EXAM	PRIMARY CARE PHYSICIAN

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

EMERGENCY CONTACT	RELATIONSHIP	CONTACT #

SPOUSE/PARENT/GUARDIAN INFORMATION

SPOUSE/PARENT/GUARDIAN	ADDRESS (IF DIFFERENT)	CELL PHONE #	DATE OF BIRTH

EMPLOYER	EMPLOYER ADDRESS	WORK PHONE #	SOCIAL SECURITY

INSURANCE INFORMATION

MEDICAL INSURANCE	ID#

POLICYHOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT

POLICYHOLDER'S EMPLOYER & ADDRESS	POLICYHOLDER'S WORK#

VISION INSURANCE	ID#

POLICY HOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT

WORKER'S COMP CLAIM?	EMPLOYER ADDRESS	CONTACT PERSON	PHONE #

SPECIAL PERMISSIONS

Please initial and date ALL statements below:

	INITIAL	DATE
I give Family EyeCare Center permission to leave voicemail/answering machine messages at my home, cell, or email	_____	_____
I give Family EyeCare Center permission to discuss my medical care/billing with:		
Name: _____ Relationship: _____	_____	_____
Name: _____ Relationship: _____	_____	_____
Notice of privacy practices has been made available……..	_____	_____

CORRESPONDANCE

We are now making greater use of electronic communication with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below. If the patient is a minor and a parent would prefer to receive communication please enter email here:

NOTE: all patient information is kept <u>strictly</u> confidential. Your address is NEVER shared.

Communication preference (please circle one): Telephone Text Message Email

Thank you for choosing Family EyeCare Center for your vision needs!

(see reverse)

SOCIAL HISTORY

(Required to document according to federal guidelines)

Height: _____ feet _____ inches Weight: _____ lbs.

Do you use tobacco products? [ ] No [ ] Yes If Yes, type: _____ amount: _____ how long: _____

Do you drink alcohol? [ ] No [ ] Yes If Yes, type: _____ amount: _____ how long: _____

Do you use illegal drugs? [ ] No [ ] Yes If Yes, type: _____ amount: _____ how long: _____

Are you pregnant and / or nursing? [ ] No [ ] Yes

Have you ever been exposed to or infected with: [ ] Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis Other: _____

NON-COVERED SERVICES

There is an additional charge for the contact lens part of our exam. Most insurance companies do not cover contact lens related office visits, so I understand the additional charge will be my responsibility. If you are a new contact lens wearer or are being fit in a different type of contact lens, there will be an additional fee. I also understand that digital retinal screening is not covered by insurance companies and if I choose to have that procedure I am responsible for the additional fee.

Signature _____ Date _____

Signature _____ Date _____

INSURANCE SIGNATURE ON FILE

_____ _____

Patient Name (Print) Medicare ID #

1. Medicare

I request that payment of authorized Medicare benefits be made on my behalf to Family EyeCare Center for services furnished to me by Family EyeCare Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to be determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Family EyeCare Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination by the Medicare carrier.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

2. Medigap

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Family EyeCare Center.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

3. Other Insurance

I authorize payment of insurance benefits be made to the office of Family EyeCare Center for any services or materials furnished. I authorize this office and the insurance company to release pertinent information so the benefits payable may be determined for the services and/or materials provided. In the event my deductible has not been met, or my insurance company does not pay in full or denies payment, I understand that I or the person responsible for the account will be required to pay the balance.

_____ _____

Signature of Patient, Parent or Legal Guardian Date