New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____
Date of Birth _____ Age _____ M / F Soc Security# _____
Address _____
Street City State Zip
Home Phone _____ Cell Phone _____
Email _____ Out of State Phone _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Employer _____ Work Phone _____
Address _____
Spouse Name _____Employer_____

Who to notify in emergency (nearest relative or friend)?
Name _____ Relationship _____
Address _____
Street City State Zip
Home Phone _____ Work Phone _____

Complete if under 18 years or a student

Name of Father _____ Employer _____
Address _____ Phone _____
Name of Mother _____ Employer _____
Address _____
Street City State Zip

INSURANCE INFORMATION

☐ Medicare # _____
☐ Other Medical Insurance _____ ID# _____
Are you personally responsible for the payment of your fees? ☐ Yes ☐ No ☐ If not, who is?
Name _____ Relationship _____

FINANCIAL ASSIGNMENT AND AGGREEMENT

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You are responsible for knowing your benefits. We verify benefits and bill your supplement as a courtesy; however, if your supplement does not pay within 30 days of your primary insurance, we will bill you for the balance owed.**
2. **In Order To Control Your Cost of Billings, We Require That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
5. **A refraction, or eye glass exam, is a non-covered service by Medicare and most insurance plans. If you have a refraction and are given a prescription for new glasses, you will incur an out-of-pocket expense of $70, payable when services are rendered. Medicare beneficiaries who undergo cataract surgery are <u>only</u> covered for a portion of the cost of new glasses, <u>not</u> refractions.**

Signed (Patient or parent if minor) _____ Date _____