Welcome to Advanced Eyecare

We are pleased to welcome you to our practice! Please take few minutes to fill out this form to ensure we have all the proper information needed. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

First Name:	MI:	Last Name:
SSN:	Date of Birth:	Sex: ❑Male ❑Female
Address:		Unit/Apt#:
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	Work Phone:
Email:	Preferred method of contact: ❑Phone ❑Text ❑Email	
Occupation:		Employer:

INSURANCE INFORMATION

We will request to scan your insurance card and/or ID

Medical Insurance:		Patient is Policyholder? ❑Yes ❑No
ID#:	Group#:	
Subscriber/Policyholder:		
Relationship to patient:	SSN:	Date of Birth:
Address same as patient? ❑Yes ❑No (If no, please fill out subscriber/policyholder address below)		
Address:		Unit/Apt#:
City:	State:	Zip Code:

Vision Insurance:		Patient is Policyholder? ❑Yes ❑No
ID#:	Group#:	
Subscriber/Policyholder:		
Relationship to patient:	SSN:	Date of Birth:
Address same as patient? ❑Yes ❑No (If no, please fill out subscriber/policyholder address below)		
Address:		Unit/Apt#:
City:	State:	Zip Code:

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FINANCIAL POLICY AUTHORIZATION

I authorize my insurance company to pay to Advanced Eyecare all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize Advanced Eyecare to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Our office does not accept responsibility for collection of negotiating and disputed insurance claim. Regardless of coverage, the undersigned is responsible for all incurred charges. Non-participating plans will reimburse you directly.
HARDWARE POLICY: Please note if contact lenses and/or eyeglasses are ordered, they are fabricated to your personal prescription and cannot be canceled once the order has been placed. When using your old frame we cannot assume responsibility for breakage that may occur in the adjustment or fabrication process.

Print name of Patient or Guardian: _____

Signature of Patient or Guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Advanced Eyecare notice of privacy practices.

Signature: _____ Date: _____

EMERGENCY CONTACT

Name:_____ Relationship to patient:_____ Phone:_____

Name:_____ Relationship to patient:_____ Phone:_____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive and/or discuss information regarding my account and/or medical records.

Name:_____ Relationship to patient:_____

❑ Financial Records ❑ Medical Records

Name:_____ Relationship to patient:_____

❑ Financial Records ❑ Medical Records

Signature: _____ Date: _____