Day of Exam – Patient Information

Welcome to our office.
To better serve you today, please fill out **BOTH** sides of this form.

Today's Date ____________________

Last Name ______________________________ First Name _____________________ Initial _____
Address ____
City _________________________________ State _________________ ZIP __________________
Home Phone _______________________________ Daytime Phone _________________________
Social Security No. _________________________ Date of Birth ___________________________
Employer __________________________________ Occupation ____________________________
E-Mail Address ____
Date of Last Eye Exam _____________In our office? No ___ Yes ___
Sex: Male ____ Female ____
Marital Status: Single___ Married___ Widowed___ Divorced___
Height: _____ft _____in
Weight: _______lbs

If you would like a report sent to any of your physicians, include their name and contact information:____

Insurance Information

Is this visit payable by insurance? Yes ___ No ___
If Yes: Name of Insurance ____
Name of Insured Member ____
Where Employed ____
Social Security # of Member ____
Members birth date ____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize my insurance company to pay all benefits for the services described to The Eyecare Center. I also understand that I am personally responsible for all charges incurred. A copy of this authorization shall be as valid as the original. I have read and understood the general office policies stated below.

Signature of Member ___________________________________ Date ________________

General Office Policies

(1) A **non-refundable** deposit is required on all materials ordered. Materials will be held for 30 days after notification for pick-up before being returned to our suppliers, resulting in **LOSS** of deposit. (2) A $25 service charge on all returned checks. (3) No-line Progressive bifocals can be remade within 30 days of dispensing to a standard FT28 bifocal at no additional charge. (4) There are **NO** refunds. (5) Opened vials or boxes of contact lenses **cannot** be exchanged. Only contact lenses purchased in our office may be exchanged. (6) Our office Notice of Privacy Practices as mandated under HIPPA is posted in the reception area of each office. A copy is available at your request at the front desk of each office. (7) Your records will be retained for a period of at least 5 years, as per federal law.

Signature of Patient /Guardian___________________________________ Date ________________
*Must be 18 years or older

COMPLETE NEXT SIDE