Price Eyecare & Optical Patient Information Sheet

How did you hear about us? □ Previous Pt □ Insurance list □ Internet
□ Friend/Family □ Walking by office □ Phone book
If friend/family who:_____

Do you wear contact lenses? □ Yes □ No □ Occasionally
Do you want an exam to become a contact lenses wearer? □ Yes □ No □ Maybe/Talk to doctor
Do you wear glasses? □ Yes □ No □ Occasionally
Do you want new glasses today? □ Yes □ No □ Maybe/Talk to doctor
Are you interested in talking to the doctor about LASIK? □ Yes □ No □ Maybe/Talk to doctor

What is your preferred method of contact? □ Phone □ Mail □ Email _____
(Used for appointment reminders and glasses/contacts pickup reminders)(We will never give out your Email or Phone numbers)

Patient's Last Name_____ **First Name**_____ **M.I.**_____

Address:_____ **City**_____ **State**_____ **Zip**_____

SSN#_____/_____/_____ **Date of Birth**_____/_____/_____ **Student? Y N** □ Male □ Female

Phone: Home#_____**Cell#**_____**Work#**_____

Emergency Contact: Name_____ **Phone#**_____ **Relationship**_____

Marital Status: M S D W **Employer:**_____ **Occupation:**_____

Primary Care Physician:_____**Phone(_____)_____-_____**

RESPONSIBLE PARTY INSURED

Policy Holder name:_____ **Primary Ins:**_____

Member ID#_____ **SSN#**_____/_____/_____ **DOB**_____/_____/_____

Relationship to Insured: □ Self □ Spouse □ Parent □ Guardian/Other

Address: □ Same as patient □ Other:_____

Is the patient covered by any other Medical/ Vision insurance policy? □ Yes □ No

If yes, name of insurance:_____**Member ID#**_____

Assignment of Benefits: I agree to have my insurance send all payments for services rendered at Price Eyecare & Optical directly to the office on the claim form. Furthermore, I agree to have any medical records copied and sent to my insurance company to facilitate getting a claim paid and processed. This assignment may be copied and used the same as an original document. By signing the below, I acknowledge that all information is true and that I am compliant with the assignmnet of benefits. **HIPAA- Patient Privacy Act*** I hereby acknowledge that I received a copy of this medical practice's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice is posted in the reception area, and I will be offered a copy of any amended notice of Privacy Practices at each appointment.

SIGNATURE*_____ **Date:**_____/_____/_____
(ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)*