PATIENT INFORMATION

Name_____ DOB _____/_____/_____ Age_____ Gender: **Male** **Female**

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email _____ How would you like us to contact you? **Email** **Postcard** **Telephone** **Text Msg**

Employer (or School)_____ Occupation _____

Primary Care Physician/Group _____ Office Phone _____

Is this your first visit to our office? **Yes** **No** Whom may we thank for referring you?_____

Marital Status? **Single** **Married** **Widowed** **Divorced** **Separated** Spouse's Name _____

If A Child, PARENT INFORMATION

Name_____

Relationship to Child _____

DOB: _____/_____/_____

Address _____

City_____ State_____ Zip Code_____

Home Phone _____ Cell Phone _____

Email _____

INSURANCE INFORMATION

Insurance Company _____

ID # _____

Group # _____

Cardholder Name _____

Cardholder DOB: _____/_____/_____

Cardholder Address _____

City_____ State_____ Zip Code_____

FAMILY INFORMATION

**We group family members together in our system. Please list members of your family who live with you or need an eye exam.*

Patient Here?		Name	Relation	DOB	Last Eye Exam
Yes	No				
Yes	No				
Yes	No				
Yes	No				
Yes	No				
Yes	No				

Authorization: I authorize any holder of medical or other information about me to release any information needed for this claim to the Social Security Administration and Health Care Financial Administration, its intermediaries or carriers, the billing agent of the supplier, Medicaid, an Insurance Company, or third party payor. I understand that I am responsible for amounts, deductibles, and charges not reimbursed by Medicare, Medicaid, my insurance company, or a third party payor. I permit a copy of this authorization to be used in place of the original signature and request payment of medical insurance benefits be paid to Focus Eye Care Center, P.C.

Advance Beneficiary Notice: I further understand that Medicaid does not pay for Vision Therapy (code 92065); Medicare does not pay for a Refraction (code 92015); and Medicaid, Medicare and Tricare do not pay for contact lens fittings (code 92310).

Privacy Notice: I have been offered a copy of the office's privacy notice or have read a copy that is on display.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____