FIRSTEYECARE
Vision Made Clear

Please complete this form in its entirety

Name _____ **Sex**_____ **Age**_____ **Date of Birth**_____

Address_____ **Single** ___ **Married**___ **Divorced**___ **Widow**___

City_____ **State**____ **Zip**_____ **SS#**_____

Home Phone_____ **DL#**_____ **State**_____

Work Phone_____ **Employer**_____

Cell Phone_____ **Occupation**_____

Preferred Communication_____ **Email**_____

Whom may we thank for referring you to our office? _____

I hereby authorize First Eye Care to release any information with respect to this claim to my insurance company. I understand that any benefits payable for good and services will be paid to First Eye Care to the extent I have not already paid part or the entire amount of such benefit.

Vision coverage is designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnosis and does not include a detailed examination of the retina. When a medical diagnosis or condition is present (such as high blood pressure, diabetes or eye disease) it may be necessary to file the visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered services. These rules are defined by the insurance carriers themselves and no by our office. WE make every effort to be on every medical carrier for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please do not hesitate to ask.

I understand that I am responsible for all goods and services not covered by insurance, which may include any contact lens services on a yearly basis.

_____ _____ _____

Patient Signature **Parent or Guardian (if minor)** **Date**

Vision Insurance: _____ Primary Name:_____
Date of Birth:_____ Social Security #:_____ Employer:_____

Major Medical Information:
Primary Ins. Company:_____ Insured ID #:_____
Policy/Group #:_____ Primary Name:_____ DOB:_____

Secondary Insurance:_____ Insured ID #:_____
Policy/Group #:_____ Primary Name:_____ DOB:_____

Please sign here if you are self-pay or will be self-pay in lieu of your insurance coverage: _____

PLEASE TURN OVER…

_____

Please Print Name

I have received a copy this office's Notice of Privacy Practices
(Available at the front desk)

_____

Signature of Patient (Parent or Guardian if under 18)

_____

Date

Please indicate below any individuals who we can release your information to: family members or other doctor's offices

_____ _____

_____ _____

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For office use only

I have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following:

Individual refused to sign: _____
Communication barriers prohibited obtainment of the acknowledgement: _____
Other (please specify): _____