Patient Information & Insurance Information

Patient Information

Name _____ Date of Birth ___/___/___ Sex M F
Preferred Name _____ Preferred Gender _____
Street Address _____
City _____ State _____ Zip Code _____
Last 4 Digits of Social Security Number (Required in order to submit Vision Insurance Claims) _____
Email Address _____
Cell Phone (____) ____ _____
May we text you at the cell phone number provided above? Y N
Home Phone / Landline (____) ____ _____
May we leave messages with a family member? Y N
May we leave messages on your answering machine at the home phone number provided above? Y N
What is your preferred method of contact for reminders?

- ❏ Text (Cell Phone)
- ❏ Email
- ❏ Home Phone

Employment Status

- ❏ Employed Full-time
- ❏ Employed Part-time
- ❏ Not Employed
- ❏ On Active Military Duty
- ❏ Part-time Student
- ❏ Full-time Student
- ❏ Retired
- ❏ Self-Employed

Marital Status

- ❏ Single
- ❏ Divorced
- ❏ Legally Separated
- ❏ Married
- ❏ Widowed

Employer (if applicable) _____
Occupation (if applicable) _____

Billing Information (Responsible Party)

Name _____
Street Address _____
City _____ State _____ Zip Code _____

Insurance Information

Please present your medical insurance card at the time of your appointment.

Enrollee Name _____ Date of Birth ___/___/___ Sex M F
Relationship to Patient _____
Street Address _____
City _____ State _____ Zip Code _____
Last 4 Digits of Social Security Number (Required in order to submit Vision Insurance Claims) _____
Employer (if applicable) _____

Routine vision exams will be filed with a patient's vision plan if one is available and we participate. A routine vision exam means there is a vision diagnosis, in the absence of a medical diagnosis. Vision diagnoses include myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, and presbyopia.

If a Medical Diagnosis (cataracts, glaucoma suspect, foreign body, diabetes, dry eye, etc) is determined by the doctor, the patient's exam is no longer routine, but medical. This means we will bill your medical health insurance and collect your medical copay and/or deductible which is required at time of service. We request a copy of your medical card in your chart for this reason.

- I understand my insurance may pay less than the actual billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependent.
- I give Richland Eye Care permission to bill my insurance for eye care services and/or products. I hereby authorize my insurance benefits to be paid directly to Richland Eye Care.
- By signing below, I agree that I have read and understand all of the above information. This signature will also serve as a record of my “Signature on File” that insurance companies require for claim processing.

Signature of patient / guarantor: _____ Date: _____
Relationship if not patient _____