

## 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 \_\_\_\_\_