

# Welcome to Our Office

Last Name \_\_\_\_\_

Sex  M  F

First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Title  Mr.  Mrs.  Miss  Dr.  Rev

Social Security Number \_\_\_\_\_

Marital Status  Married  Single  Widowed  Other

Nickname \_\_\_\_\_

Employee Status  Employed Full time

Employed Part Time

Are you the head of your household?  Y  N

Student Full Time

Who is financially responsible for your account?

Self Employed

Not Employed

Retired

(Primary insured or adult if patient is a minor)

Employer/School \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Address \_\_\_\_\_

How did you hear of us?  Family Member

City \_\_\_\_\_

Insurance

State \_\_\_\_\_ ZipCode \_\_\_\_\_

Professional referral

Home Phone \_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Yellow Pages

Daytime Phone \_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Patient Referral

Cell Phone \_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Who referred you? \_\_\_\_\_

Can we send you text confirmations? Y N

Preferred Language  English Other: \_\_\_\_\_

Email Address \_\_\_\_\_

Race  American Indian  Asian

Black or African American  Hispanic

White  Other

WE DO NOT SHARE YOUR INFORMATION WITH ANYONE. WE USE YOUR CONTACT INFORMATION TO CONFIRM APPOINTMENTS, SEND CORRESPONDENCE, APPOINTMENT REMINDERS, AND TO LET YOU KNOW YOUR GLASSES OR CONTACTS ARE IN.

How can we contact you?  Email  Text  Home Phone  Work Phone  Cell Phone

Can we leave a voice message?  Yes  No \_\_\_\_\_ INITIALS

# Insurance Information

Our office provides both medical and vision examinations. Most vision insurances are connected to your medical insurance. Many medical insurance plans include comprehensive eye examinations. Medical fees may apply towards your deductible. Medical copays are often less than vision copays. For these reasons, we respectfully request that you submit both vision and medical insurance information.

## Medical Insurance *Please provide a copy of your medical insurance card to the front desk.*

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_ Social Security Number \_\_\_\_\_

Insured ID \_\_\_\_\_ Policy Group Number \_\_\_\_\_

Is there a secondary medical insurance?  Yes  No Name of Secondary Health Insurance \_\_\_\_\_

Insured ID (Secondary) \_\_\_\_\_ Policy Group Number (Secondary) \_\_\_\_\_

Relationship to insured  Self  Spouse  Child  Other \_\_\_\_\_

### Insured Party (if other than yourself)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_ Sex  M  F DOB \_\_\_\_\_

## Vision Insurance *Most vision plans do not have their own card: we need the following to obtain an authorization.* No Vision Insurance

Name of Vision Insurance \_\_\_\_\_ Relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Primary insured information *if different* than above.** If it is the same, you can skip this part.

Is it the same as above?  Yes

Last Name Primary Insured \_\_\_\_\_ First Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_ Sex  M  F DOB \_\_\_\_\_

## Authorizations

I certify that I have insurance coverage with the above forenamed health and/or vision insurance company(ies) and assign directly to Riverside Eye Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**Medicare/Medigap Authorization:** I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to Riverside Eye Clinic for any services furnished to me by that provider. I understand I am responsible for services not covered.

I give consent for Riverside Eye Clinic to discuss financial information with the primary insured if other than myself.  Yes  No Initials \_\_\_\_\_

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage please contact your insurance representative. We do not guarantee the accuracy of the benefit information given to us by your insurance companies!!! **Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company.**

I authorize the release of all medical or other medical information necessary to process insurance claims. I authorize payments of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

Signed \_\_\_\_\_ Date \_\_\_\_\_

I attest I have read and have received or had the opportunity to receive a copy of Riverside Eye Clinic's Notice of Privacy Practices per HIPAA laws.

Signed \_\_\_\_\_ Date \_\_\_\_\_