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

(Primary insured or adult if patient is a minor) ☐ Retired

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 Inititals_____

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_____