New Patient Information

Name:

Address: City: State: Zip:

Phone – Home: Cell: Work:

Sex: Marital Status: Race:

Social Security Number: Date of Birth: / / Age:

Email Address:

Primary Language: Present Employer:

Referred by:

Primary Care Physician: Pharmacy Name:

Spouse Name:

Emergency Contact: Phone:

Do you presently wear glasses? ○ Yes ⊙ No Do you wear sunglasses? ○ Yes ⊙ No

Do you presently wear contacts? ○ Yes ⊙ No If not, are you interested in trying contacts? ○ Yes ⊙ No

Insurance Information

Please bring your all your insurance cards, including Medicare and Medicaid, to the front desk. All co-pays, co-insurance and/or deductibles are due the day of your office visit.

Insurance Company: Member Name:

Member Date of Birth: Member Address:

Member Phone: Member ID:

Group Number: Relationship to Patient:

I request that payment authorized by Medicare and/or insurance benefits be made to Family Eye Care for any services furnished to me by Dr. Amy Bishop. I authorize any holder of medical information about me be released to the health care financing administration and its agents/or any authorized insurance company any information needed to determine these benefits payable for related services. I understand that my signature may be kept on file for this purpose indefinitely.

This office is a Medicare participating provider. We bill Medicare directly and accept assignment. You will be responsible for payment of the annual deductible if it has not been met, 20% of Medicare allowed charges and all Medicare non-covered services. Refractions are not covered by Medicare.

My signature below confirms that I have read and agree to the above statements.

Patient Signature: Date:

Parent Signature if Patient under 18: