SKELTON EYE CARE PC

PATIENT INFORMATION

NAME: ______________________

NICKNAME: ______________________

STREET ADDRESS: ______________________

DATE OF BIRTH: ______________________

CITY/STATE/ZIP: ______________________

SOCIAL SECURITY NUMBER: ______________________

HOME PHONE: (   ) ______________________

GENDER: **MALE / FEMALE** AGE: ____________

CELL PHONE: (   ) ______________________

WORK PHONE: (   ) ______________________

PHARMACY: ______________________

E-MAIL ADDRESS: ______________________

We are committed to keeping your e-mail address confidential. We do not sell, rent, or lease e-mails to third parties, and we will not provide your personal information to any third-party individual, government agency, or company at any time unless compelled to do so by law.

PREFERRED METHOD OF CONTACT (please check one)

- ◯ **CALL HOME PHONE**
- ◯ **TEXT CELL PHONE**
- ◯ **CALL CELL PHONE**
- ◯ **E-MAIL**

WOULD YOU LIKE TO HAVE ACCESS TO YOUR MEDICAL RECORD VIA A SECURE ON-LINE PATIENT PORTAL (E-MAIL REQUIRED)? **YES / NO**

RESPONSIBLE PARTY INFORMATION (IF PATIENT UNDER 18)

NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

ADDRESS: ______________________

DATE OF BIRTH: ______________________

ADDRESS LINE 2: ______________________

SOCIAL SECURITY NUMBER: ______________________

PREFERRED PHONE: (   ) ______________________

INSURANCE INFORMATION

ROUTINE VISION INSURANCE

INSURANCE NAME: ______________________

POLICY HOLDER: ______________________

EMPLOYER: ______________________

RELATIONSHIP TO PATIENT: ______________________

◯ CHECK IF **"SELF"**

POLICY HOLDER DOB: ______________________

POLICY HOLDER SSN: ______________________

MEDICAL INSURANCE

PRIMARY INSURANCE NAME: ______________________________

IF MEDICARE, LIST CO-INSURANCE: ______________________________

POLICY HOLDER: ______________________________ EMPLOYER: ______________________________

RELATIONSHIP TO PATIENT: ______________________________ ◯ CHECK IF **"SELF"**

POLICY HOLDER DOB: ______________________________ POLICY HOLDER SSN: ______________________________

SECONDARY INSURANCE NAME (IF APPLICABLE): ______________________________

POLICY HOLDER: ______________________________ EMPLOYER: ______________________________

RELATIONSHIP TO PATIENT: ______________________________ ◯ CHECK IF **"SELF"**

POLICY HOLDER DOB: ______________________________ POLICY HOLDER SSN: ______________________________

I ATTEST THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES (ATTACHED) AND AGREE TO THE FINANCIAL RESPONSIBILITY STATEMENT OUTLINED BELOW:

Our office is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most modern eye care in our area.

Please be aware that some, and perhaps all, of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other medical and vision insurers. These services may be required to be paid in full at the time of your visit or after we receive your explanation of benefits.

You are responsible for any co-pays, co-insurance, deductible and other non-covered services. Any surcharges for spectacle upgrades set by your vision insurance must be paid at the time of service before any orders will be processed. If you are a self-pay patient and/or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept cash, personal checks, MasterCard, Visa, and Discover Card. If you are being seen for any ongoing medical problem, co-pays are due at each visit. If you foresee any payment problems, please speak to the doctor prior to your appointment.

______________________________ ______________________________

PATIENT SIGNATURE (PARENT OR GUARDIAN IF UNDER 18) **DATE**