

Amador Eye Care

Welcome To Our Office

2nd Ins. Pays Refraction

Yes No

Primary Eye Care

Yes No

Vsp Authorization # _____

Above is for office Use only

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Mr. Miss Mrs. Ms. Dr.

Appointment Date: _____

Appointment Time: _____

Provider: _____

Male Female

First Name _____

MI _____

Last Name _____

Preferred Name _____

Mailing Address _____

City _____

State _____

Zip _____

Social Security Number _____

Date of Birth _____

Contact Phone - Area Code _____

Ext: _____

Home Phone - Area Code _____

Day/Cell Phone - Area Code _____

Work Phone - Include Area Code _____

Spouse/Partner/Other _____

Parents/Guardians
(Only If Patient Is Under 18.)

Your Current Occupation _____

Your Current Employer _____

Your Regular Physician's Name _____

(If Patient Is A Minor, Occupation And Employer Do Not Need To Be Completed)

Email: _____

Most Recent Eye Examination: _____

Doctor: _____

City _____

INSURANCE INFORMATION

Name of Primary Insurance Company _____

Name of Secondary Insurance Company _____

Insured's First Name _____

Insured's Last Name _____

Insured's Identification Number _____

Insured's Social Security Number _____

Insured's Date of Birth _____

Patient Relationship to Insured

Patient Status

Single Married Other

Self Spouse Child Other

Full Time Student Part Time Student Employed

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy. Notification is therefore given that the office of Amador Eye Care will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising. Is it however understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context: Patient registration; Procure medical records from former physicians; Converse with colleagues for opinions/care; Insurance: verifications, billing, paper and wire (includes fax transmissions); Insurance company follow up or interaction with billing services relating to patient care; Pursue collection of unpaid bills; Hospital workers, nurses, aids and medical records department; Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses or technicians; Personal Religious designate; Pharmacists, drug program personnel/workers; Completion of disability forms; Computer and electronically stored information, (i.e. related business vendor and service persons) I authorize the release of this necessary information

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance.

I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____

Date _____

Parent/guardian(s) signature is required if the patient is under the age of 18.

Notes From Dr:

 Dilating Done

Office Use Only : OptoMap: YES NO (this is an extra charge due at time of service.)