Patient Information

Date:______________________

Name:____

Date of Birth:________________________________ Sex: M / F

Address:____

City:_________________________State:____________Zip:_________________

Preferred Phone #:________________________________ Cell Work Home

Secondary Phone #:_______________________________ Cell Work Home

Email:____

Referred By: Friend/Family Another Dr. Insurance list Walk by Flyer New Prosperity Magazine

Name of Employer:____

Insurance Information

Medical Insurance:____

Member ID:____Group #:_____________________________________

Insured Name:___________________________________Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Insured Date of Birth:____________________________ Insured ss#_____________________________________

Vision Insurance:____

Policy #:____ ID #______________________________________
(Do not need if EyeMed)

Insured Name:___________________________________Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Insured Date of Birth:____________________________ Insured ss#_____________________________________

Advanced Beneficiary Notice (ABN)

All insurance Patients: The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision and or medical insurance. Patients will be billed for any un-met deductibles, co-insurance, etc. I authorize payment of insurance benefits to Focus EyeCare. I agree to be financially responsible for any balance not paid by my insurance plan. I understand that professional fees are non-refundable.

Patient/Guardian signature:____Date:__________________

HIPPA Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Patient/Guardian signature:____Date:__________________

Dilation Refusal

I do NOT agree to have my eyes dilated today and understand the risk of missed ocular diseases and conditions.

Patient/Guardian signature:____Date:__________________