Patient Information

Mr..
Mrs
Ms.
Name___*Dr.*_____ **Date**_____
Circle one ***First*** ***M.I.*** ***Last***

Address_____
Street ***Apt. #***
_____
City ***State*** ***Zip Code***

Phone: **Home** ( ) _____ **Work** ( )_____ **Cell** ( )_____

Date of Birth ____/_____/_____ **Social Security Number** _____

Sex ____M_____F **Race** _____ **E-mail** _____

Occupation _____ **Employer** _____

Whom may we thank for referring you? _____

Name of vision insurance: _____

Policy Holder: _____Policy Holder Date of Birth_____

ID or membership #: _____Group #: _____

Employer: _____

Name of medical insurance: _____

Policy Holder: _____Policy Holder Date of Birth_____

ID or membership #: _____Group #: _____

Employer: _____

Secondary Insurance: _____

Policy Holder: _____Policy Holder Date of Birth_____

ID or membership #: _____Group #: _____

Employer: _____

If patient is minor: Name of parents or guardians: _____

Address: _____

_____

Phone: ( )_____

I understand, confirmed by my signature below, that all discount plans or insurance information must be submitted at time of services rendered and/or products ordered, in order to utilize the benefits. Hemler Family Eye Care will not honor benefits for discounts on prior services rendered and/or products ordered. I understand, confirmed by my signature below, that all glasses and contacts are custom made when ordered and therefore are non-refundable.

X_____ **X**_____
Patient or guardian signature ***Date***

I have provided complete and accurate insurance information, in good faith. I understand that if my insurance company fails to pay for a properly submitted claim for services rendered on my behalf, and/or for my family members, that I am responsible for the payment, and will render it promptly. I understand that all services and materials not covered by insurance are to be paid promptly. I authorize Hemler Family Eye Care to add interest and/or collection service fees to any amount I owe which is past due. I authorize Hemler Family Eye Care to release any medical or other information about me to my insurance company in order to process claims on my behalf. My signature on this form will stand as my Signature on File.

X_____ **X**_____
Patient or guardian signature ***Date***

Revised 11/11/08