Patient Information

Name: _____ Date: _____ Birth Date:_____

Gender: Male Female Social Security #:_____ Current medical Dr._____

Mailing Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Texting OK? _____

Communication Pref:. Email Postal Telephone Email Address_____

Employment Status: _____ Employer: _____ Work Pone: _____

Occupation: _____ Marital Status: _____ Race: _____ Ethnicity: _____

Preferred Language: _____ Height: _____ Weight: _____

Responsible Party Information

Person Responsible for Account_____

Relation to Patient_____ Soc. Sec. #_____ D.O.B._____

Address (if different from patient)_____

Insurance Information

Primary Insurance_____ policy # _____ Group #_____

Secondary insurance_____ Policy # _____ Group # _____

Financial information

I herby give my consent to Shippee Family Eyecare, P.C. or any doctors at this location to provide eye care services to myself and/or any party for whom I am legally responsible. I understand that I am ultimately responsible, regardless of my insurance status, for any charges incurred by me or any party for whom I am legally responsible.

Signed:_____ Date:_____

Information Authorization

I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to my doctor. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

Medicare Waivers

I understand that Medicare does not pay for service code 92015 "Refraction," I will be responsible for this charge of $30.00. I understand that Medicare does not pay for glasses except for the first pair following Cataract surgery.

Signed: _____ Date: _____

Acknowledgement of Privacy Policy

I acknowledge that I have viewed and been offered a copy of the privacy policy for Shippee Family Eyecare, P.C.

Signed: _____ Date: _____