OPTIC GALLERY

NEW PATIENT INFORMATION FORM

Patient information Today's Date:_____

Last Name:_____ First Name:_____ M.I._____

Address:_____ City, State, Zip:_____

Birthdate:_____ Age:_____ Hobbies:_____

Hm phone:_____ Cell phone:_____

Occupation:_____ Email:_____

Emergency Contact:_____ Phone #:_____

*Who may we thank for referring you to us?*_____

Would you like to opt out of text correspondence? Y / N email correspondence? Y / N

Responsible Party (if different from above)

Name of person responsible for account if not the patient:_____

Address:_____ City, State, Zip:_____

Hm phone:_____ Cell phone:_____

Employer:_____ Relationship to patient:_____

Insurance Information

Insurance:_____ Group:_____

Subscriber:_____ ID #:_____

Patient's relationship to subscriber: Self Spouse Child Dependent

Subscriber's employer:_____ Subscriber's date of birth:_____

Please read and sign below

We will be happy to bill your insurance for you as a *courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager.

I acknowledge that I have completed all of the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third party payers and/or other health practitioners if needed. **Lastly, I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given.**

X_____ Date:_____