PATIENT INFORMATION

PLEASE COMPLETE FORM IN BLACK INK

Name: ____ Date:______________
Last First Middle

Date of Birth: _____________ Age: ____ Gender: M F (Circle) Social Security #______________

Address:_________________________________City:___________________ St:_____ Zip:__________

Home Phone: _____________________ Work: ____________________ Mobile: __________________

Email Address: ______________________________ Employer:______________________________

Preferred Method of Phone Contact: Mobile Home Work (Please Circle One)

Would you like to receive notifications via text? Yes No (Please Circle One)

NOTE: TEXT MESSAGE NOTIFICATIONS ARE AVAILABLE TO MOBILE NUMBERS ONLY

Date of Last Exam? _________________________ Where? __________________________________

Marital Status: Single Married Divorced Widowed Separated Minor Child (Please Circle One)

Student Status: Full-Time Part-Time Not a Student (Please Circle One)

If Patient is a minor, lives with (name):____________________________ Relationship:_____________

Phone: ____________________ Address:____

INSURANCE INFORMATION

MUST BE FILLED OUT COMPLETELY IN ORDER FOR US TO FILE YOUR INSURANCE

Primary: ____ ID#_________________________

Subscriber Name:_______________________________ DOB:____________ Relationship:__________

Secondary: ____ ID#________________________

Subscriber Name:_______________________________ DOB:____________ Relationship:__________

Vision: ____ ID#________________________

Subscriber Name:_______________________________DOB:____________ Relationship:__________

Subscriber's Employer: ____

PERSON RESPONSIBLE FOR PAYMENT

IF YOU ARE RESPONSIBLE FOR PAYMENT CHECK THIS BOX ☐

Name: ____ DOB:_________ SS#____________
Last First Middle

Address:_________________________________City:___________________ St:_____ Zip:__________

Home Phone: _____________________ Mobile: ____________________ Work: __________________

RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY STATEMENT

PLEASE COMPLETE FORM IN BLACK INK

I authorize the release of any medical information necessary to process insurance claims and authorize payment of **medical** benefits to Brinegar Eye Care. **I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED BY BRINEGAR EYE CARE TO ME OR MY DEPENDENTS**. If BEC is not a participating provider in my insurance plan, I understand that payment is required at the time of service.

REFRACTION FEE

A **refraction** is a test to obtain your best corrected vision, to determined the need for eye glasses, surgery, and/or medicine. Most medical insurance plans, including Medicare, do not cover refractions. Our office will collect the refraction fee along with any co-payment at the time of service. Any additional testing and contact lens fitting fees may not be covered under your insurance plan.

RETURNED CHECKS

A charge of $25 will be made for NSF or returned checks. If a third party is involved to resolve payment for services provided by BEC, I agree to be responsible for collection agency fees, attorney fees, and court costs, interest or other charges incurred.

SIGNATURE IS REQUIRED

X____ **Date:**_________________________

Signature of patient or legal guardian

NOTICE OF PRIVACY PRACTICES / RELEASE OF MEDICAL INFORMATION

Your medical information is personal to you and by law, Brinegar Eye Care is required to make sure that it is kept private. You may obtain a copy of our privacy policy by request.

On occasion a family member, friend, or caregiver may contact Brinegar Eye Care to inquire about your medical information. Please list those individuals to whom the information may be disclosed.

Name:____ Relationship:______________________

Name:____ Relationship:______________________

Name:____ Relationship:______________________

Name:____ Relationship:______________________

SIGNATURE IS REQUIRED

X____ **Date:**_________________________

Signature of patient or legal guardian

EMERGENCY

In case of an emergency, please contact:

Name________________________________ Phone:______________ Relationship:_______________

Name________________________________ Phone:______________ Relationship:_______________