Welcome to Fidler EyeCare

Patient Information

Thank you for choosing our office for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. ***Please print****.*

Name_____ Date_____
First Middle Initial Last

If Child, Parent's Name_____ Spouse_____

Address _____ Apt_____ City _____ State___ Zip _____

Birth date _____ Age _____ Home Phone _____Work Phone _____

Cell Phone_____ email address_____

Occupation _____Employer_____

Person to Contact in case of emergency _____ Phone _____

How did you hear about our office? _____

Responsible Party

Payment is due when services are rendered. We accept cash, local checks, Visa, Mastercard, American Express and Discover. Please present Photo ID when paying by check or credit card.

Name of person responsible for this account? _____

Relationship to Patient _____ DL # _____

Insurance Information

Please present your insurance card(s) so that we can make a photocopy for our records.

Name of Insured_____ Relationship to Patient_____

Birthdate _____ Social Security # _____ Date employed _____

Name of Employer _____ Work Phone # _____

Plan _____Group _____

Additional Insurance Plan _____ Group _____

Authorization

I authorize Craig A. Fidler, O.D., P.A. / Fidler EyeCare (provider) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the provider insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*_____Date_____

I acknowledge that I have received a copy of Craig A. Fidler OD PA/Fidler EyeCare's Notice of Privacy Practices.

*X*_____*Date*_____