Claflin Eye Care
For A Lifetime of Vision Health

Welcome To Our Office

1 Patient

Name: ____________________ Age: _____ DOB: __________

Street Address: ____________________ Home Phone: __________

City: __________ State: ______ Zip: ________ Cell Phone: __________

Occupation: __________ Employer: __________ Social Security #: __________

If student, grade/ year: __________ School: __________ Email Address: __________

Spouse (or Parent's) Name: ______________ Major Reason for Visit: ______________

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Ethnicity: ❑ White ❑ Hispanic ❑ Black ❑ Native American ❑ Asian

2 Insurance Information

Please list your ***vision plan*** and primary ***medical insurance.***

Vision Plan ______________________

Subscriber Name ______________________

Subscriber SSN ______________________

Subscriber Birth Date ______________________

Medical Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________________

Subscriber Birth Date ______________________

Do you participate in a flex spending account?

❑ Yes ❑ No

How will you settle your account today?

❑ Cash ❑ Check ❑ Credit Card

3 New Patients/ Referred by

Whom may we thank for referring you to our office? ______________________

If not referred, how did you choose our office for your needs?

❑ Another Doctor ❑ Reputation ❑ Yellow Pages________ ❑ Newspaper/Radio/TV

❑ Insurance List ❑ Location/ Signage ❑ Website____________ ❑ Other ____________

4 Vision Needs

Do you....(Check box if answer is yes)

- ❑ Wear Glasses?
- ❑ Wear Contacts?
- ❑ Work at a computer? _____hrs./wk.
- ❑ Spend time outdoors? _____hrs./wk.
- ❑ Have prescription sunglasses?
- ❑ Prefer not to wear your glasses at times?
- ❑ Have Children?
- ❑ Want information on Laser Vision Correction surgery?
- ❑ Have interest in a non-surgical approach to vision correction?
- ❑ Have more than one pair of current Rx glasses?
- ❑ Have family members in need of eyecare?
- ❑ Think you might benefit from thinner, lighter lenses?
- ❑ Want to "Test Drive" the latest contact lens designs?

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

If you wear contact lenses, are you satisfied with the vision and comfort? ❑ Yes ❑ No

5 Vision Conditions

Have you ever been diagnosed or treated for the following?

❑ Cataracts ❑ Macular Degeneration ❑ Cataract Surgery ❑ Eye Infection(s) ❑ Lazy Eye

❑ Glaucoma ❑ Retinal Detachment ❑ Eye Injury ❑ Iritis/Uveitis ❑ Eye Muscle Surgery

6 Vision Symptoms

Are you currently experiencing any of the following?

❑ Blurred Vision ❑ Dry, Burn, Itch ❑ Light Flashes ❑ Light Sensitivity ❑ Trouble Seeing at Night

❑ Double Vision ❑ Discharge/ Red Eye ❑ Floaters ❑ Difficulty Reading ❑ Crossed Eyes/ Eye Turn

❑ Eye Pain ❑ Foreign Body Sensation ❑ Headaches ❑ Other: ______________________

7 Signature on File

Claflin Eye Care Payment Policy

Account Payments: In order to minimize your health care costs, we request payment when services are rendered. All Glasses, Eyewear, and Contact Lenses must be paid in full prior to ordering.

We will bill your insurance if we are a participating provider or prior arrangements have been made. If your insurance company decides not to cover or pay for services rendered, you are responsible for any co-pays and any remaining fees not covered. **Note:** if after 60 days (from date of service) your insurance company has not responded, the balance owed will become your responsibility.

If you have payment(s) due to our clinic, we send out statements bi-monthly until paid in full.

Patient acknowledges that should they not pay this account and it is assigned to a collection service, s/he will be liable for any collection fees charged by the agency plus any other collection costs, reasonable attorney fees, and court fees.

Claflin Eye Care Assignment of Benefits

Assignment of Benefits: I authorize payment of benefits on my behalf to this clinic and to all independent contractors providing services to me at this clinic.

Authorization to Release Information: I authorize this clinic to release diagnostic and clinical information to third party payors for claims and to referring physicians for my continued health care.

Medicare Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and request that authorized payment of Medicare benefits be paid directly to this doctor or office.

Supplemental/ Private Insurance: I authorize my vision and/ or supplemental insurance to submit payment directly to this doctor or office for coverage of services rendered under his care. I understand that this office will help bill supplemental (or secondary) insurances and that I may have to submit for these services myself.

Non-covered Services: I understand that Medicare and some insurances do not cover refractive services. This is the part of the exam in which the doctor is determining if a spectacle prescription or change is needed. The cost of this service and any **other non-covered service(s)** provided has/have been explained to me.

I certify that I am the patient (or I am duly authorized by the patient to act on his/ her behalf), that this form has been fully explained to me, that I understand its content and significance, and that I accept the terms of this agreement.

Signature: ______________________________ **Date:** ______________