COMPLETE EYE CARE
seemorelivebetter.com

Patient Information

☐ MR. ☐ MS. ☐ MRS. ☐ MISS ☐ DR. ☐ REV.

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

Nickname: _____ Email: _____ SSN: _____-_____-_____

Mailing Address: _____ Apt. #_____

City: _____ State:_____ Zip:_____ Drivers Licence: _____

Cell: (_____) _____-_____ Home: (_____) _____- _____ Other : (_____) _____-_____

Preferred Contact Method: ☐ Cell ☐ Text ☐ Home ☐ Email ☐ Other

Date of Birth (MM/DD/YYYY) : _____ / _____ / _____ Sex: ☐ Male ☐ Female

Employer or School:_____ Job Title or Year in School:_____

Name of Spouse:_____ Are they a patient here? ☐Yes ☐No

If patient is a minor, list name of parents: _____

How did you hear about our office?

☐Previous Patient ☐ My Insurance Company ☐ Search Engine ☐ Location ☐ Facebook ☐ Instagram

☐ Referred by a friend/family/doctor *(please list*) Referred by:_____

If you do not fill out this section below, your spouse or family members will not be able to access your medical information with our office.

I _____ authorize Complete Eye Care to disclose my personal health information to (listed person(s) below)

Name	*Relationship to Patient*
_____	_____
_____	_____
_____	_____

X _____ Date: _____

Patient or Responsible Party Signature

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I certify that I am financially responsible for any charges incurred, regardless of whether or not I (or my dependent) have insurance coverage. I authorize the doctor to release all information necessary to secure payment of benefits from my insurance company/companies listed on the back of this form. I understand and agree it is my responsibility and not the responsibility of the doctor or the staff to know if my insurance will pay for any medical or vision service I receive, if I have a deductible to meet, any co-payments, co-insurance due for services rendered, out-of-network benefits, or any type of benefit information for the medical or vision service I receive.

I Authorize the use of this signature on all insurance submissions and/or my acceptance of financial responsibility for services rendered without having insurance.

X_____ Date: _____

Patient or Responsible Party Signature

INSURANCE INFORMATION

Primary Medical: _____ **ID**: _____ **Group**: _____

My Policy Holder Is:

☐ *Myself* ☐ *Someone Else (please fill out information below)*

Name:_____ DOB: _____ Phone: _____

SSN: _____-_____-_____ Mailing Address:_____ Apt:_____

City:_____State:_____ Zip:_____ Employer:_____

Secondary Medical: _____ **ID**: _____ **Group**: _____

My Policy Holder Is:

☐ *Myself* ☐ *Same As Above* ☐ *Someone Else (please fill out information below)*

Name:_____ DOB: _____ Phone: _____

SSN: _____-_____-_____ Mailing Address:_____ Apt:_____

City:_____State:_____ Zip:_____ Employer:_____

#1 Vision Plan: _____ ID: _____ Group: _____

My Policy Holder Is:

☐ *Myself* ☐ *Same As Above* ☐ *Someone Else (please fill out information below)*

Name:_____ DOB: _____ Phone: _____

SSN: _____-_____-_____ Mailing Address:_____ Apt:_____

City:_____State:_____ Zip:_____ Employer:_____

#2 Vision Plan: _____ ID: _____ **Group**: _____

My Policy Holder Is:

☐ *Myself* ☐ *Same As Above* ☐ *Someone Else (please fill out information below)*

Name:_____ DOB: _____ Phone: _____

SSN: _____-_____-_____ Mailing Address:_____ Apt:_____

City:_____State:_____ Zip:_____ Employer:_____

PRIVACY POLICY / HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment both directly and indirectly, obtain payment from third party payers, conduct normal healthcare operations such as quality assessments and physicians certification. I have received/been offered, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

X_____ Date: _____

Patient or Responsible Party Signature

TELE-SERVICES ACCEPTANCE

I authorize Complete Eye Care to contact me by telephone or other media devices for communications needed to monitor my progress and recommended care.

X_____ Date: _____

Patient or Responsible Party Signature