

Patient Information

Date _____

Thank you for choosing our practice 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 _____ D.O.B. _____ SS/HIC/Patient ID# _____
First Middle Initial Last

If all of the information below is the same as the information recorded on your previous visit please indicate by writing "same" on the following line. If anything has changed please make corrections below. If this is your first visit, please continue to provide the requested information. Thank you. _____

Address _____ City _____ State _____ Zip _____

Email: _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: D Home H Work Cell C No Preference

N Married M Widowed W Single S Minor M Separated S Divorced D Partnered for _____ years

Patient Employer/School _____ Occupation _____

Spouse or parent's name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (____) _____

Responsible Party

Name of person responsible for this account/Head of Household _____

Relationship to patient _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (____) _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? D No N Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

Health History

Name _____ Date _____
Reason for today's exam _____
Date of last eye exam _____ Name of Doctor _____
Date of Last Physical Exam _____ Name of Doctor _____

If all of the information below is the same as the information recorded on your previous visit please indicate by writing "same" on the following line. If anything has changed please make corrections below. If this is your first visit, please continue to provide the requested information. Thank you. _____

Do you or anyone in your immediate family have a history of the following?

D Diabetes D Blindness B High Blood Pressure H Cataracts C Thyroid T Turned or Lazy Eye T
Glaucoma G Heart Condition

Please check any of the following conditions that apply to you:

P Frequent headaches F Drug allergies D Pregnant P Allergies A Sinus trouble S Given birth in the last 6
mths

Please list all medications you are currently taking _____

Have you ever had any of the following conditions involving your eyes?

H Eye Surgery E Sensitivity to light S Eye infection or disease E Eye injury E Floaters or spots F Double
vision v Medical treatment M Eye strain E Poor distance vision P Severe pain S Poor near vision
P Eyes burn, itch or water

Do you currently wear glasses? D Yes Y No

If you currently wear glasses, when do you wear your glasses? I All the time A Reading/near work
R Work safety W Distance tasks only D Computer work C Other, please
explain _____

Have you ever worn contacts? H Yes Y No Are you interested in wearing contact lenses? N Yes Y No
If so, what style? I Soft S Extended Wear E Gas Permeable G Disposable DBifocal BTinted
Astigmatic/Toric A Unsure

Do you work at a computer or video display terminal? D Yes Y No Hours/Day _____

What hobbies or sports do you participate in? _____

Do you have any specific concerns about your eyes or vision that you would like the Dr. to address? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Fairview Family Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Fairview Family Eye Care may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Date

FAIRVIEW FAMILY EYE CARE
INSURANCE/FEE POLICY

The doctors and staff of Fairview Family Eye Care take pride in the superior service and patient care that we give to you, our patient. Your eye and visual health are our top concern. In an effort to avoid confusion regarding payment for our service, please review the following policies.

Payments/Co-payments are due at the time service is rendered. We participate in numerous insurance plans. For some insurance plans we accept assignment of benefits but in all cases we require the guarantor, the person who is financially responsible, to assume responsibility and is personally liable for all balances not covered by insurance. **While we will make every effort to verify and confirm your insurance benefits, it is your responsibility to understand the terms and conditions of your insurance plan.** Please understand; however, that you are still responsible for payment if the claim is denied or is not paid within 30(thirty) days of submission. For your convenience, our office accepts major credit cards, bank debit cards, personal checks with a valid ID, and cash. **Please also be advised that all returned checks will have a \$35 return check fee applied.**

Please be aware that some of the services provided may be non-covered services.

A deposit of at least 50% is due before any materials are ordered. The remaining balance of the order is due within 30(thirty) days of order placement. Materials that are not paid and picked up after this 30(thirty) day period are returned, and **any money paid is lost.**

Frames over \$300 may be pre-paid before ordering. Payments must be received at least monthly. If 30 days elapse without payment, the frames are returned and **any money paid is non-refundable.**

Most frames and lenses are warranted for a full year after purchase. (Warranty does not apply to budget packages.) There is a \$35 service fee for frame or lens replacement during the warranty period. An extended warranty is available for patients who wish to extend their coverage another year.

ALL FEES ARE NON-REFUNDABLE. Services and materials are tailored to fit the needs of each patient and cannot be re-sold; therefore, fees are not refunded.

No-show Fee. Appointment times are reserved exclusively for you; we do not overbook our schedule. If you need to reschedule your appointment, we kindly request that you give us 24 hours of advanced notice. A no-show fee of \$25.00 is added to the account of patients that miss their appointments and/or do not provide at least 24 hours of advance notice. This fee is not covered by insurance.

Please sign below to indicate that you have read and understand the policies.

Parent/Guardian Signature

Date