# Welcome to Our Office

## PATIENT INFORMATION

Date _____

Last Name _____

First Name _____ Middle Initial _____

SSN# _____

Address _____

City, State, Zip _____

Home Phone ( ) _____

Work Phone ( ) _____

Cell Phone ( ) _____

E-mail: _____

**NOTE: Your email address is for our internal use only. We will NEVER share or sell this information to others!**

Date of Birth _____ Sex: M / F

Age _____ Marital Status _____

Referred by _____

Your Occupation _____

Your Employer _____

Employer's Address _____

City, State, Zip _____

Spouse's Name _____

Parent's Name _____

Emergency Contact Name _____

& Phone Number _____

## INSURANCE INFORMATION

**(Please present your insurance card(s) to receptionist.)**

(Please Circle Below if Applicable)

**PRIMARY INSURANCE: PPO HMO Medicare**

Insurance Company _____

Group Number (if any) _____

Insured's Name _____

Insured's Social Sec. or I.D. # _____

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child

Insured's Date of Birth (if other than self) _____

Primary Care Physician _____

(Please Circle Below if Applicable)

**SECONDARY INSURANCE: PPO HMO Medicare**

Insurance Company _____

Group Number (if any) _____

Insured's Name _____

Insured's Social Sec. or I.D. # _____

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child

Insured's Date of Birth (if other than self) _____

## Please Read and Sign Payment Policy Below:

A "REFRACTION" is a procedure that measures the focusing power of your eyes and allows the physician to determine whether new prescription glasses will help you to see better.

Medicare and most other medical insurance plans **DO NOT** pay for the refraction portion of your eye examination. Some **VISION** plans such as "Vision Service Plan (VSP)" or "Medical Eye Services (MESC)" **DO** cover refractions. Unless you have such a vision plan, you are responsible for paying the refraction fee, as well as any insurance deductibles or co-pays, at the time of your visit. If you have any questions about this policy, feel free to ask.

By signing below, I state that I understand and agree that, regardless of my insurance status, I am responsible for payment of refraction fees.

Signed: _____ Date: _____

ONE to ONE

*LASIK*
*Cataract Surgery*
*Eye Care*

www.LASIK121.com