

# WELCOME

## PATIENT INFORMATION



Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Preferred Communication:  Phone  Email  Mail

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Minor:  Y\*  N  
SSN: \_\_\_\_\_  
Sex:  M  F  
Marital Status:  Single  Married  Widowed  Divorced  
Employment Status:  
 FT  Retired  Unemployed  FT Student  
Employer \_\_\_\_\_  
How did you learn about our office?  
 Family/Friend  Insurance  Location  Sign  
 Other \_\_\_\_\_

### **\*If Minor, Parent or Guardian Information:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
SSN: \_\_\_\_\_  
Email \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  
Relationship to Patient: \_\_\_\_\_

### **Insurance Information** *Please present all insurance cards and drivers license. Without complete information, we will be unable to file insurance on your behalf.*

#### **Primary Insured**

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Vision Insurance \_\_\_\_\_  
Medical Insurance \_\_\_\_\_ Vision ID # \_\_\_\_\_  
Medical ID # \_\_\_\_\_

#### **Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with the above listed companies and assign directly to Richard C. Weaver, O.D. and his associates 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 insurance. I authorize the use of my signature on all insurance submissions.

#### **HIPPA (Acknowledgement of Receipt of Privacy Notice)**

By signing this acknowledgement of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have received a copy for my files or have been offered a copy of the Notice of Privacy Practices for review on the date identified below. I understand that Belton Eye Care Center may use and disclose necessary health information for purposes of treatment, payment, and healthcare operations.

\_\_\_\_\_  
Signature of Patient (\*If minor, signature of responsible party)

\_\_\_\_\_  
Date

#### **Baseline Retinal Photographs**

Your eye doctors request baseline retinal photographs today so that they may make factual medical judgments concerning the health of your eyes for years to come. Insurance will NOT cover the baseline photographs.

I elect the Baseline Retinal Photographs today (\$28.00)  I do not elect the Baseline Retinal Photographs today

\_\_\_\_\_  
Signature of Patient (\*If minor, signature of responsible party)

\_\_\_\_\_  
Date