Family Focused Eye Care

 NEW PATIENT INFORMATION FORM

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| Today’s Date  | FFEC Primary Doctor  |
|  PATIENT INFORMATION  |
| Title Mr. Mrs. Ms. Miss  | First name | MI | Last name | Preferred Name (if it differs)  |
| Address  |
| Date of birth | Sex  | Marital status  | SSN:(if 18 or older)  |
| Cell phone  | Home phone  | Work phone (if different) | Other phone |
| Email | Best form of comm. Call Text Email | Occupation |
| Responsible party(if different from above)  | Relationship to patient | Resp. party’s best phone number |
| How were you referred to our office?  |

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| ***http://www.clipartbest.com/cliparts/MTL/kB4/MTLkB4zjc.pngVISION* INSURANCE 1** **Insurance card provided** |  | ***http://www.clipartbest.com/cliparts/MTL/kB4/MTLkB4zjc.pngVISION* INSURANCE 2** **Insurance card provided** |
| Subscriber’s Name (Last, First, MI) |  | Subscriber’s Name (Last, First, MI)  |
| Subscriber’s DOB  | Patient’s relationship to subscriber |  | Subscriber’s DOB  | Patient’s relationship to subscriber |
| Insurance Name  | Insured SSN  |  | Insurance Name | Insured SSN  |
| ID # | Group #  |  | ID # | Group #  |
| Employer  |  | Employer |

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| ***Staff of Asclepius by TmeluMEDICAL* INSURANCE 1** **Insurance card provided** |  | ***Staff of Asclepius by TmeluMEDICAL* INSURANCE 2** **Insurance card provided** |
| Subscriber’s Name (Last, First, MI)  |  | Subscriber’s Name (Last, First, MI)  |
| Subscriber’s DOB  | Patient’s relationship to subscriber |  | Subscriber’s DOB  | Patient’s relationship to subscriber |
| Insurance Name  | Insured SSN  |  | Insurance Name  | Insured SSN  |
| ID # | Group #  |  | ID #  | Group #  |
| Employer  |  | Employer |

I hereby certify that the above information is true and correct to the best of my knowledge.

I agree to pay for co-pays, deductible, co-insurance, and non-covered services. If a balance remains after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. I understand delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court cost, and a collection agency fee of 33.33% which will be added to the outstanding balance of my account with or without suit.

Payment from my insurance is to be paid directly to Family Focused Eye Care. I understand that the above primary insurance will be billed on my behalf. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_