Family Focused Eye Care

NEW PATIENT INFORMATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_