HORIZON EYE CARE PATIENT INFORMATION FORM

PATIENT INFORMATION TO BE COMPLETED IN FULL

Patient's Name: ____________________________ **Date of Birth**: _________**Male/Female**_______
Full legal name: no nicknames First Middle Init Last

Please circle : *This information is requested due to Healthcare Reform laws dictated by Congress.*

Race: American Indian Asian Black Native Hawaiian White Multi-racial

Ethnicity: Hispanic/Latino Non-Hispanic/non-Latino

Preferred Language: English Spanish Other___________

Marital Status: ____________________________Your Social Security #: __________________________________

____
Street Address **APT #** **City** State Zip Code

Home Phone: ________________________ Your Alternate or Cell Phone **REQUIRED** _____________________

EMAIL____ Work Phone: ________________________________

Employer: ____________________________Address:________________________________Phone___________

Who referred you to us?___________________________________May we send a thank you?________________

Who is your family physician: ________________________ City:______________Phone Number:____________

May we contact this physician concerning your treatment, diagnosis, & care? ☐ Yes ☐ No

Is today's related to a work injury?__________Date of injury?________________

Is today's related to an AUTO injury?__________Date of injury?______________

Who is your **Vision Plan Carrier** (Covers Exams for New Glasses): _____________________________________
For example: VSP, Davis, Optum, Eyemed

VISION PLAN ID:____

You must present identification and your insurance cards to the receptionist each time you come to the office

#1 Primary Medical Insurance Carrier: ____

What is your Policy Number (ID #) ______________________________ Group #: ____________

Who is the Subscriber: ____M or F
Full NAME
DATE OF BIRTH:________________________ RELATIONSHIP TO YOU_________________________________
Subscriber's SOCIAL SECURITY NUMBER____

#2 Secondary Medical Insurance Carrier: ____

What is your Policy Number (ID #) ______________________________ Group #: _________________

Who is the Subscriber: ____M or F
Full NAME
DATE OF BIRTH:________________________ RELATIONSHIP TO YOU_________________________________
Subscriber's SOCIAL SECURITY NUMBER____

If it is necessary to discuss your personal health information with someone other than yourself, please list the name/s and phone number/s of the person/s we should contact. If no one is listed under federal regulations, we are prohibited from speaking with anyone else concerning your care.

Person to Contact: _____________________Relationship:____________ Phone Number: _______________

Person to Contact: ____________________Relationship_____________ Phone Number: ________________

Authorizations

A. I hereby authorize Horizon Eye Care and/or any of its employees to bill any and all of my insurance providers for services rendered to me by the physicians and/or staff of Horizon Eye Care. I authorize the release of any of my personal health information so that benefits may be paid directly to Horizon Eye Care.
B. I authorize Horizon Eye Care to access & process my prescription and medicine information electronically.
C. If a referral is required by my insurance, I understand it is my responsibility to have it prior to my visit at Horizon Eye Care.
D. I acknowledge that I have received the Horizon Eye Care Notice of Privacy.
E. I acknowledge appointment reminders and other printed materials will be mailed to me unless I request electronic format.
F. I acknowledge that this authorization will remain in effect from the date of my below signature unless I change it.
G. I acknowledge that I am financially responsible for any and all charges related to my visit. Once my insurance company has replied to the claim, it is my responsibility to resolve any and all outstanding balances or issues with the insurance company.
H. **I acknowledge that any applicable copay is due on date of service. If not paid, I will be charged an additional $10 service fee**.
I. I acknowledge that any balance after 60 days is subject to late fees, interest and possibly court fees for which I am responsible.

Patient's Signature: ______________________________________ Today's Date: ___________________

Revised 2/24/2011