

New pt form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender: _____ Marital Status: _____
 Female Male Single Married Domestic Partner Separated Divorced Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Preferred contact method:
 Mobile Phone Home Phone Email Texting

Last 4 of SSN

2. What type of MEDICAL insurance do you have?

- | | | |
|---|---------------------------------|------------------------------------|
| <input type="checkbox"/> Blue Cross Blue Shield | <input type="checkbox"/> Aetna | <input type="checkbox"/> Anthem BC |
| <input type="checkbox"/> Blue Care Network | <input type="checkbox"/> Humana | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Medicare Advantage | <input type="checkbox"/> None | |

Please provide ID number if available

3. What type of VISION insurance do you have?

- | | | |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Vision Service Plan (VSP) | <input type="checkbox"/> Eyemed | <input type="checkbox"/> Spectera |
| <input type="checkbox"/> National Vision Administrators (NVA) | <input type="checkbox"/> Heritage | <input type="checkbox"/> None |

Please provide ID number if available

4. Have you ever been diagnosed or have any of these conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Diabetes type 1 |
| <input type="checkbox"/> Diabetes type 2 | <input type="checkbox"/> Dry eye | <input type="checkbox"/> Eye inflammation |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Floaters and/or Flashes of light | <input type="checkbox"/> Iritis or Uveitis |
| <input type="checkbox"/> Retina defects | <input type="checkbox"/> None | |

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Vision Associates of Westland for all insurance benefits otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I understand that I am responsible for the balance of any orders that I place, especially a product specifically ordered to my prescription or measurements.

I understand that I will be charged a re-billing fee of \$5.00 if my balance is not paid within 30 days.

I authorize the doctor and/or any provider or supplier of services in this office to release the information in this office to release the information required to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I understand that there is a \$20 charge for retinal scans that most of the time will replace being dilated.

I have read and understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Signature

Signature