Welcome to Millard Family Eyecare

Patient Information

Patient's Name_____ Mr. Mrs. Dr. Miss Ms. Rev.

Address_____

City_____ State_____ Zip_____

Birthdate_____ Age_____ Sex M F

Employer_____ Occupation_____

Spouse's Name (if applicable)_____

Family Physician_____

Phone Numbers & Contact Information

Home Phone_____ Work Phone_____ Cell Phone_____

Email address:_____

What is the best time to reach you:_____

Preferred method to reach you: ☐Home ☐Work ☐Cell

Please list any other members of your household who come to our office_____

_____

If you are a **new** patient how did you find out about our office?:

☐ Insurance ☐ Family ☐ Yellow Pages ☐ Internet

☐ Physician ☐ Drive By ☐ Other_____

Who referred you to our office? (Name)_____

Acknowledgement of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Millard Family Eyecare's Notice of Privacy Practices.

_____ _____

(Signature) (Date)

Assignment & Release

I hereby authorize Millard Family Eyecare to furnish to the insurance company all information which said insurance company may request concerning my present eye condition, illness or injury. Information may also be disclosed to the referring physician or to other health care providers, facilities, or agencies. I hereby assign to Millard Family Eyecare, the amount of money to which I am entitled for medical and/or vision expenses for each claim submitted. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

(Signature) (Date)

Please Note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please discuss this with the receptionist.