Dr. Don Robbins, Optometrist

GENERAL PATIENT INFORMATION

PHONE:_____ DATE:_____

CELL PHONE:_____  SILENCE YOUR CELL PHONE during your appointment due to sensitive electrical equipment

PATIENT'S NAME:_____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS:_____
(CITY, STATE, ZIP CODE)

PHYSICAL ADDRESS:_____
(CITY, STATE, ZIP CODE)

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____ AGE:_____

EMAIL:_____ MARITAL STATUS(circle one): Single/Married/Divorced/Widow(er)

EMPLOYER:_____
(OCCUPATION) (WORK PHONE)

EMPLOYER'S ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP CODE)

SPOUSE'S NAME:_____ WORK PHONE:_____

CONTACT PERSON:_____ PHONE:_____

How did you know we were here: (Circle One)

Previous patient, health dept., newspaper, school, sign, yellow pages, family/friend referral_____

If patient is under 18, complete parental information. If not, proceed to box.

BOTH PARENTS (or guardian):_____

EMPLOYER OF FATHER:_____ WORK PHONE:_____

EMPLOYER OF MOTHER:_____ WORK PHONE:_____

FINANCIAL POLICY

Payment is expected when services are performed. Financial arrangements should be made with our financial assistant **before** you begin treatment. Vision insurance may help pay on routine exams. Major medical insurance may help pay for vision exams on diseases of the eyes (example: cataracts, glaucoma, diabetes, hypertension…). **If you have insurance, please advise us.** We will help you to file your claim so you may be reimbursed.

Preferred method of payment: (Circle One)

Check Cash Credit/Debit Card Medicare Peachcare Medicaid

A $30.00 SERVICE CHARGE IS REQUIRED FOR ALL RETURNED CHECKS.

INSURANCE AUTHORITY & ASSIGNEMENT

I request that payment of authorized Medicare/Other insurance company benefits be made to Dr. Don Robbins, for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. The patient is responsible for the deductible, co-insurance, and non-covered services, which are the charges determined by your insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or Insurance Company claim. I permit a copy of this authorization to be used in place of the original.

Our office strives to protect the privacy of all patients by observing **HIPPA** compliances. These regulations may be reviewed by request.

I hereby certify that I am financially responsible for all fees charged regardless of insurance coverage.

Signed_____ Date_____