PATIENT INFORMATION

First Name:

Last Name:

Date of Birth:

Address:
City, State, Zip:

Home Phone: Cell Phone: SSN:

Email address:

Employment status: Full Time ☐ Part Time ☐ Student Status: Full-Time ☐ Part-Time ☐
Retired ☐

Marital Status: Single ☐ Married ☐
Divorced ☐ Widowed ☐

Race: American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐
Asian ☐ Other ☐
Black or African American ☐ White ☐
Hispanic ☐ Decline to Specify ☐

Ethnicity: Hispanic or Latino ☐ Native Hawaiian/Other Pacific Island ☐
Not Hispanic or Latino ☐ Decline to Specify ☐

Preferred Language:

Where did you hear about us?

Current Medical Condition

Do you have any current vision concerns? (Near, far, glare, floaters, etc)

Do you have any current health issues? (Blood pressure, cholesterol, diabetes, etc)

Are you currently taking any medications? If so, please list them here:

Do you currently have any allergies?

CONTACT LENS PATIENTS: The fit of your lenses must be evaluated annually in order for a new prescription to be written. There will be an additional fee, due at the time of your exam, for your contact lens evaluation. These fees range depending on the type of fit. This fee may be covered, in part, by your insurance - usually with a copay that is determined by your insurance company.

SIGNATURE (Parent if Minor): Date:

Insurance Information

Please present insurance cards, for both vision and heath, at the time of check-in. Our office policies, and some insurance plans, require you to present your current card before services can be rendered with the expectation of coverage. All co-pays and fees that are not covered by insurance are due at the time of your visit – please make sure we have all pertinent information.

Responsible Party/Primary Policy Holder (If different than patient)

First Name:	Last Name:	Date of Birth:
Address:	City, State, Zip:	
Home Phone:	Cell Phone:	Daytime Phone:
Email address:		

Vision Insurance Information

Name of Insured:	Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Insurance Company:	Insurance ID #:

Medical Insurance Information

Name of Insured:	Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Insurance Company:	Insurance ID #:
Do you have secondary medical insurance?	Yes ☐ No ☐
If yes, who is the insurance carrier?	

If you do not want us to bill any insurance, or if you are paying for your visit out of pocket, please initial here:

_____

Authorization to bill insurance

1. I request that the payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Rosenstein Vision Center for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the **Health Care Financing Administration** and its agents any information needed to determine these benefits payable for related services.

2. In any event that your insurance denies any or all of our claims, you will be responsible for any remaining balance owed.

SIGNATURE:_____ DATE:_____

HIPAA

By signing below, I authorize the Rosenstein Vision to use any protected health information, or PHI, in any of the following circumstances:

1. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. In addition, we may use and disclose PHI about you when referring you to another health care provider for additional care.

2. Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services we provided to you. Specifically, sharing information with your health plan (s) allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following:

- Billing departments
- Collection departments
- Insurance companies, health plans and their agents which provide you coverage

3. I am aware that there is a copy of this office's Notice of Privacy Practices as required by HIPPA in each examination room, in the waiting room, and at the front desk. All of these copies are available for my review while I am in the office.

SIGNATURE:_____ DATE:_____