DRS. DRIVER & CLARK, P.A.

GENERAL PATIENT INFORMATION

Today's Date: _____

Name: _____ **M.I.** ____ **Preferred Name or Nickname:** _____

Date of Birth: _____ **Sex:** M / F **Marital Status:** Single Married Divorced Widowed

Spouse/Partner/Significant other/name: _____ **Emergency Contact:** _____

Mailing Address: _____ **City/St/Zip:** _____

Primary Phone#: _____ home or cell **Other Phone #:** _____ home or cell

***Email address:** _____ **Preferred way to contact you:** _____

***Your email address is required to access your eyeglasses and/or contact lens prescription electronically via your patient portal**

Occupation: _____ **Employer:** _____ **Work Phone#:** _____

How did you learn about our services &/or who can we thank for referring you to our clinic?

_____

If you are under 18 who are your parents or legal guardians? _____

PAYMENT FOR SERVICES AND PRODUCTS

Examination fees including insurance co-payments and deductibles are due on the day of the examination. Optical orders require a 50% deposit with the balance payable in full upon dispensing.
If you are not responsible for your own charges, who is & what is their address, phone number, and date of birth?

Name: _____ Date of Birth: _____ Phone#: _____

Address: _____City, State, Zip: _____

[ ] GENERAL INSURANCE AUTHORIZATION: "RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS"

I request that any payment from my insurance benefits be made to Drs. Driver & Clark, P.A. on my behalf for services provided to me by them in accordance with this assignment. To accomplish this, I authorize the release of any medical information about me to assist in determining benefits payable for me. I understand that my signature below requests that my benefits be made directly to Drs. Driver & Clark, P.A., and that I am responsible for items not paid for me by my insurance, such as co-pays, deductibles and non-covered services. In signing this I understand that my insurance may not cover my entire account in full and that I will be responsible for all fees not covered in this assignment.

X _____ _____

Patient Signature (or responsible party) Date

If insurance is carried by someone other than you, please fill out below for the insured who carries the plan:

Name: _____ Relationship to the patient: _____
Address: _____ City, State, Zip:_____
Date of Birth of insured: _____ Place of Employment: _____
Primary Phone Number: _____ Work Phone Number: _____

[ ] NOTICE OF EXCLUSION FOR MEDICARE BENEFITS {NEMB)

I have been informed and understand that my Medicare insurance will not pay for my entire health care costs and I understand that Medicare only pays 80% of allowable services after a deductible has been met. If I have a Private Medicare Plan (ex. PFFS, HUMANA, ADVANTRA) I understand that I also must pay a co-pay amount. I also understand that Medicare does not pay for routine eye examinations and refraction testing.

X_____ (Initial)