NEW PATIENT INFORMATION

Today's Date: _____ Email Address: _____

PERSONAL INFORMATION – (Please Print)

Patient Name: _____ Age: _____

Address: _____ City _____ State _____ Zip _____

Home/Day Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____

Date of Birth: _____ S.S. #: _____ Sex: Male / Female
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed☐

Race (Optional) Black – Non Hispanic ☐ American Indian/ Alaskan Native ☐ Hispanic ☐
Asian/Pacific Islander ☐ White – Non Hispanic ☐ Other ☐

Employment Status Employed ☐ Unemployed ☐ Retired☐ Disabled ☐

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Employer: _____ Work Phone: _____

Preferred Reminder by: **TEXT** ☐ **HOME/WORK/CELL PHONE** ☐ **EMAIL** ☐

Primary Care/ Family Doctor: _____Address: _____

Referred by:
☐ Friend/Relative _____ ☐ Doctor: _____

How did you find us? (Please check all that apply):
☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Online ☐ Other: _____

Who to notify in an emergency (nearest relative or friend)?

Name: _____Relationship: _____

Address: _____ Phone: _____

INSURANCE INFORMATION (Please bring insurance cards to the front desk)

Primary Insurance: _____ # _____
Co-pay Amt: _____

Name of:
Policyholder: _____Social Security # _____
Date of Birth: _____

Secondary Insurance: _____ # _____
Co-pay Amt: _____

Name of:
Policyholder: _____Social Security # _____
Date of Birth: _____

COMPLETE IF UNDER 18 YEAR OLD OR A STUDENT - (Please Print)

Name of Father: _____Social Security # _____
Employer: _____
Address: _____ Phone: _____

Name of Mother: _____ Social Security # _____
Employer: _____

Address: _____ Phone: _____

Patient Name: _____

FINANCIAL ASSIGNMENT AND AGREEMENTS

- I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.

- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Ad Astra Eye for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

- I understand that I am financially responsible for all charges not covered by insurance.

- Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

- I give permission to Ad Astra Eye to access records regarding my medical conditions.

- I authorize Ad Astra Eye to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.

- I agree to the release of my medical information to my personal physician(s), or optometrist(s).

- **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

1. _____ 2. _____

3. _____ 4. _____

I acknowledge that a copy of **Notice of Privacy Policy** and **Financial Policy** has been provided to me for review and that a copy is available at my request.

Signature: _____ Date: _____
(Patient or legal guardian)

Witness: _____ Date: _____
(Practice Representative)