AD ASTRA EYE
M. Scott Hickman, MD

PATIENT DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION – (Please Print)

Patient Name: _____ Date of Birth: _____ SS# _____

Sex: M F Marital Status: Single Married Divorced Widowed Spouse's Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Preferred Reminder by: HOME/WORK/CELL PHONE ☐ EMAIL ☐

Employer: _____ Occupation: _____

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

Primary Care Doctor: _____ Address: _____

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

Emergency Contact:
Name: _____ Relationship: _____

Address: _____ Phone: _____

GUARANTOR INFORMATION Financially Responsible Party for Dependent Patients (18 & Under Only)

Guarantor Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Policyholder Name: _____ Relationship: _____

Policyholder Date of Birth: _____ Policyholder SS# _____

Secondary Insurance: _____ Policy #: _____

Policyholder Name: _____ Relationship: _____

Policyholder Date of Birth: _____ Policyholder SS# _____

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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 or if I am a self-pay patient.

- Some medical insurances (example: Medicare) do not pay for a **refraction test or vision test.** It is a test needed to detect any underlining medical conditions. I agree to be personally be responsible for this 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. _____ Relationship_____

2. _____ Relationship_____

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.

Patient Name (Please Print): _____

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

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