Wichryk Eye Associates, P.C.

PATIENT INFORMATION FORM

Please complete this form as clearly and completely as possible, and bring it with you at the time of your appointment. This form will allow us to expedite your appointment. *Please Print*

Name: (Dr., Mr., Mrs., Miss, Ms.)_____ **Date:**_____
First Initial Last

Nickname:_____ **Social Security Number:**_____

Please Circle: Single Married Divorced Widowed Minor Partnered

Address:_____
Street or Box City State Zip

Date of Birth:_____ **Sex:** M F

Communication Preference & Consent
Cell phone numbers and E-mail addresses are very important to our appointment confirmation process and notification of spectacle and contact lens orders. These will not be shared with outside sources.

Home Phone _____ Daytime Phone _____

Cell Phone _____ Is Texting OK? YES or NO E-Mail _____

Language: **___English ___Spanish ___Declined to Specify ___French ___Japanese**

Race: **___American Indian/Alaska Native ___Asian ___Black/African American ___Hispanic**

___Native Hawaiian/Pacific Islander ___White ___Declined to Specify

Place of Employment: _____ Occupation: _____

If student, school attending and grade level: _____

Family Doctor: _____

Pharmacy Name: _____ Pharmacy Address: _____

Who referred you to our office: _____

In case of emergency, who should we notify?

Name: _____ Phone Number: _____

Release of Information

If you would like to have information released to someone other than yourself, please complete the following: Please list names of AUTHORIZED people:

SPOUSE:_____ CHILD(REN): _____

PARENT: _____ CHILD(REN): _____

OTHER: _____

Patient/Guardian Signature_____ **Date** _____

INSURANCE INFORMATION

Primary MEDICAL Insurance

Name of Primary MEDICAL Insurance: _____ Referral Required __YES __NO

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Address: _____ Policy Holder's Employer: _____

ID Number: _____ Group Number: _____

Secondary MEDICAL Insurance

Name of Secondary MEDICAL Insurance: _____ Referral Required __YES __NO

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Address: _____ Policy Holder's Employer: _____

ID Number: _____ Group Number: _____

VISION Insurance Information

Name of VISION Insurance: _____

Policy Holder's Social Security #:_____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Address: _____ Policy Holder's Employer: _____

ID Number: _____ Group Number: _____

If the patient is a minor, list the name and address of the person financially responsible for the minor's account.

Name: _____ Date of Birth: _____

Address: _____

Billing and Financial Policy

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare or other applicable benefits be paid on my behalf to Wichryk Eye Associates, PC for any furnished services. I authorize Wichryk Eye Associates, PC to release any medical or other information about me to any private insurance company, Medicare and or other company and its agents, which might provide coverage to me.

All Services are the Responsibility of the Patient: Wichryk Eye Associates, PC will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due.

Payments, Co-pays and Deductibles are due at the time of service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays, and deductibles at the time of service for all services and materials.

Returned Checks: There is a $30 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Patient Name (print): _____

Signature of Patient/ Parent if Minor: _____ Date: _____