Eyesight Ophthalmic Services, P.A.

155 Borthwick Avenue, Suite 200 East, Portsmouth, NH 03801 (603) 436-1773

Please provide the name of your primary EYECARE provider: _____

PATIENT INFORMATION

NAME (Last, First, Middle Initial)			SSN #	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP		PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN	
HOME PHONE	DAY PHONE	SECONDARY HOME PHONE/CELL PHONE		EMAIL ADDRESS		
SECONDARY ADDRESS (If applicable)			CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS FULL TIME ☐ PART TIME ☐	SMOKER (Y/N) ?	VETERAN (Y/N) ?	EMERGENCY CONTACT NAME	CONTACT PHONE	

RESPONSIBLE PARTY INFORMATION (If different than above)

NAME (Last, First, Middle initial)			SSN #	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP		PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN	
HOME PHONE	DAY PHONE	SECONDARY HOME PHONE/CELL PHONE		EMAIL ADDRESS		
SECONDARY ADDRESS (If applicable)			CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS FULL TIME ☐ PART TIME ☐	SMOKER (Y/N) ?	VETERAN (Y/N) ?	EMERGENCY CONTACT NAME	CONTACT PHONE	
RELATIONSHIP TO PATIENT						

EMPLOYER INFORMATION

PRIMARY EMPLOYER	ADDRESS
CITY, STATE, ZIP	WORK PHONE
SECONDARY EMPLOYER (If Applicable)	

INSURANCE INFORMATION: PLEASE PRESENT ALL PERTINENT INSURANCE CARDS TO THE STAFF.
IN ORDER TO SUBMIT YOUR VISIT TO YOUR INSURANCE, WE NEED YOUR CARD TO VERIFY BILLING INFORMATION AND ID#.

PRIMARY INSURANCE	POLICY SUBSCRIBER	SUBSCRIBER DOB
SECONDARY INSURANCE	POLICY SUBSCRIBER	SUBSCRIBER DOB

INSURANCE POLICIES THAT ARE HMO USUALLY REQUIRE A REFERRAL FROM YOUR PRIMARY CARE DOCTOR FOR YOUR VISIT TO BE COVERED. IF YOUR EXAM IS BEING BILLED AS ROUTINE A REFERRAL IS NOT REQUIRED.

MY VISIT TODAY IS: **ROUTINE** **MEDICAL** (PLEASE CIRCLE)

IF YOU SELECTED ROUTINE:
DO YOU HAVE A ROUTINE EYECARE BENEFIT THROUGH YOUR MEDICAL INSURANCE? **YES** **NO** (PLEASE CIRCLE)

IF YOU SELECTED MEDICAL:
DOES YOUR POLICY REQUIRE AN INSURANCE REFERRAL TO SEE A SPECIALIST? **YES** **NO** (PLEASE CIRCLE)

I UNDERSTAND THAT EYESIGHT *DOES NOT* PARTICIPATE WITH ANY VISION SERVICE PLANS. _____ **(INITIAL)**

FOR EXAMPLE (BUT NOT LIMITED TO): VSP, EYEMED, DAVIS VISION, CIGNA VISION, BLUE VIEW VISION AND SPECTERA.

IF MY INSURANCE DOES NOT COVER MY EXAM, OR IT IS SUBJECT TO DEDUCTIBLE, COINSURANCE, ETC, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY SUCH BALANCE AND EYESIGHT IS CONTRACTUALLY REQUIRED TO HOLD ME RESPONSIBLE. THE INSURANCE POLICY I HAVE PRESENTED TODAY IS MY OWN AND IT IS MY RESPONSIBILITY TO KNOW MY BENEFITS.

_____ **(INITIAL)**

REFRACTION IS THE PROCEDURE IN WHICH YOUR DOCTOR WILL TEST YOUR VISION USING DIFFERENT LENSES TO SEE IF YOUR VISUAL ACUITY CAN BE IMPROVED. A GLASSES PRESCRIPTION CAN BE WRITTEN FROM THIS TEST. INSURANCE COVERAGE FOR REFRACTION IS VARIABLE AND PLAN SPECIFIC. MEDICARE DOES NOT COVER THIS SERVICE.

I UNDERSTAND THAT A REFRACTION MAY BE NECESSARY AS PART OF MY EXAM AND IS OFTEN A NON-COVERED SERVICE WITH INSURANCE. A REFRACTION FEE IS $50.00 AND I MAY RECEIVE A BILL FOR THIS SERVICE. _____ **(INITIAL)**

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

NextGen Registration form edited 6/4/18