

# 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
MAILING 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 <input type="checkbox"/> PART TIME <input type="checkbox"/>	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 <input type="checkbox"/> PART TIME <input type="checkbox"/>	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)	

For your convenience, we offer a safe and simple way to access your medical information, pay your bill on line and more. For access to this information, please authorize and complete the following:

I WOULD LIKE TO RECEIVE MY BILLING STATEMENTS ELECTRONICALLY:    \_\_\_ YES    \_\_\_ NO    \_\_\_\_\_ (INITIAL)

Email address for statements:

I WOULD LIKE TO RECEIVE TEXT REMINDERS FOR APPOINTMENTS    \_\_\_ YES    \_\_\_ NO    \_\_\_\_\_ (INITIAL)

Cell number to text reminders:    (    )

**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 THROUGH INSURANCE. A REFRACTION FEE IS \$50.00 AND I MAY RECEIVE A BILL FOR THIS SERVICE.    \_\_\_\_\_ (INITIAL)

SIGNATURE OF PATIENT/GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_