

Eyesight Ophthalmic Services, P.A.

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

Who is 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

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 _____