Eyesight Ophthalmic Services, P.A.

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

Patient Information (Please Print Clearly)					
Last Name, First Name, Middle Initial:		Marital Status:	Social Security #:	Date of Birth:	Sex:
Language:	Ethnic Group & Race:	Preferred Contact Method: (Circle One) Phone Patient Portal Mail	Emergency Contact Name: _____ Phone #: _____		
Patient Home Phone #:	Patient Work Phone #:		Patient Cell Phone #:		
Preferred Phone Number: (Circle One) Home Work Cell	Is it okay to leave a detailed message? Yes No		Email Address:		
Patient Mailing/Billing Address:					
Primary Care Physician: (Name/City, State)		Referring Physician: (Name/City, State)			

If an email and cell phone are provided, we will email you a billing statement and send appointment reminders via text or email. Once you receive your first bill or appointment reminder, you will be given the option to OPT OUT. This will stop electronic billing statements and appointment reminders. All future billing statements will be mailed and appointment reminders will be a phone call.

Does your insurance require a referral? (If your card says **HMO** or **EPO** typically referrals **are required**) **YES NO**
(If you have Medicare, they do NOT require a referral and they do NOT cover Routine Eye Care)

Is this visit to follow a medical diagnosis? (Example: Cataracts, Dry Eye, Glaucoma, Diabetes, etc.) **YES NO**

If this visit is NOT to follow a diagnosis, do you have a Routine Eye Care Benefit under your Medical Plan (NOT through a Vision Service Plan)? **YES NO**
(Examples of vision service plans: Davis Vision, EyeMed, VSP, Blue View Vision, Cigna Vision, and Spectera, etc.)

I understand Eyesight does NOT participate with any Vision Service Plans. _____(Please Initial)

<u>If my insurance does not cover my exam, or it is subject to a deductible, co-pay, coinsurance, etc.,</u> I understand that I will be responsible for any such balance and Eyesight is contractually required to hold me responsible for such balance. The insurance policy I have presented today is my own and it is my responsibility to know my benefits. _____(Please 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. <u>MEDICARE DOES NOT COVER THIS SERVICE</u>.
I understand that a refraction may be necessary as part of my exam and is often a non-covered service with insurance. <u>A refraction fee is $50.00 and I may receive a bill for this service</u>. _____(Please Initial)

Have you received your Pneumonia Vaccine? **YES NO**
Do you have an Advanced Directive (Living Will, Health Care Proxy, Power Attorney, etc.)? **Yes NO**
Do you smoke? **YES NO**

Signature Of Patient/Guardian _____ Date _____