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	CELL PHONE / SECONDARY 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

MAILING OR LOCAL ADDRESS	CITY, STATE, ZIP	PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

HOME PHONE	DAY PHONE	CELL PHONE / SECONDARY PHONE	EMAIL ADDRESS

SECONDARY ADDRESS (If applicable)	CITY, STATE, ZIP

RELATIONSHIP TO PATIENT

In an effort to go Green, we will be emailing you a billing statement and emailing or texting appointment reminders. Once you receive your first bill and/or appointment reminder, you will be given the option to OPT OUT. You will only be sent one message electronically if you elect to opt out of either. Future statements would be mailed and future appointments reminders would be called or sent via text.

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: MEDICAL

DOES YOUR POLICY REQUIRE AN INSURANCE REFERRAL TO SEE A SPECIALIST? **YES** **NO** (PLEASE CIRCLE)

MY VISIT TODAY IS: ROUTINE

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

I UNDERSTAND THAT EYESIGHT *DOES NOT* PARTICIPATE WITH ANY VISION SERVICE PLANS.

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

If my insurance does not cover my exam, or it is subject to a deductible, co-pay, 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 you 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 _____