Welcome To

EYEWORLD VISION CENTER

Please provide your contact information

IF YOU NEED HELP COMPLETING THIS FORM PLEASE LET US KNOW

A PATIENT INFO

Today's Date _____

Patient Name _____
Last Name

Patient's Date of Birth _____

_____
First Name Middle Initial

Employer/School _____

Address _____

Spouse's Name _____

City _____

Spouse's Date of Birth _____

State _____ Zip Code _____

Spouse's Employer _____

Occupation _____

Whom may we thank for referring you? _____

B CONTACT INFO

Cell Phone Number ( ) _____ Do you receive text at this number? ☐ Yes ☐ No

Home Number ( ) _____ Work Number ( ) _____

EMAIL ADDRESS Please print clearly

Please print clearly

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Number ( ) _____ Cell Number _____

Would you like to receive text and/or email notifications for the following?

☐ Yes ☐ No **Glasses are ready to pick up.**

☐ Yes ☐ No **Contact lenses are ready for pick up.**

☐ Yes ☐ No **Special unadvertised offers.**

We will never share, sell, or rent individual personal information with anyone without your advance permission or unless ordered by a court of law. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending you emails or texts based on your request for information.

Please tell us about your vision and medical insurance on the other side.

C **Most insurance providers require us to have a copy of an up to date insurance card or other proof of insurance coverage on file. A copy of a current picture ID may also be required. Please provide this information to the front desk.**

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Who is responsible for this account?_____Relationship to Patient_____

Insurance Provider_____ Social Security Number_____

Subscriber's Name_____ Subscriber's Date of Birth_____

Insurance Number_____ Group Number_____

Secondary Insurance Provider_____

Secondary Insurance Number_____

ASSIGNMENT and RELEASE

I certify that I and/or my dependents, have insurance coverage with_____ and assign directly to Eyeworld Vision Center and/or Optometry Exchange of Alabama all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named entity may use my health care information and may disclose such information to my insurance carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

With the advent of the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare" most insurance providers require you to pay or *meet* a deductible prior to them paying anything towards your health care costs. In addition to the deductible, there may also be a copay that you will be required to pay. Please understand these fees are instituted by your insurance carrier and we are required to collect them.