

DRUID HILLS EYECARE

ADULT & PEDIATRIC OPTOMETRY DATE: mm/dd/yy \_\_\_\_\_

Mr., Mrs., Ms., Miss.

Patient's Name: \_\_\_\_\_  
Last First Middle / (Preferred Name)

Date of Birth: \_\_\_\_\_  
mm/dd/yyyy

Phone: home: \_\_\_\_\_ work: \_\_\_\_\_

Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation: \_\_\_\_\_

SS Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

**If Child, please indicate Parent(s) or Guardian(s):**

Father: \_\_\_\_\_ phone: \_\_\_\_\_

Mother: \_\_\_\_\_ phone: \_\_\_\_\_

Address if different from above: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_ soft or hard

Are you interested in Contact Lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

LASIK Surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Person to notify in case of emergency: (not at the same address) \_\_\_\_\_

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ relationship: \_\_\_\_\_

*Welcome to our office*

**I. INSURANCE INFORMATION/ VISION PLAN:**

____ VSP	____ Spectera	____ Supervision
____ Davis Vision	____ Eyemed	____ Vision Care
____ Other _____		

**POLICY HOLDER'S NAME:** \_\_\_\_\_

**INSURED'S ID NUMBER:** \_\_\_\_\_

**INSURED'S DATE OF BIRTH:** \_\_\_\_\_

**II. AUTHORIZATION:**

**Medical Insurance Authorization:**

I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize release of any medical information necessary to process this claim and also certify that the information contained herein is correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Lifetime Authorization-Medicare:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due when services are rendered. A finance charge of 1½ % PER MONTH (18% per year) will be billed on unpaid balances greater than 30 days old. Please feel free to discuss our policies and fees with us. We strive to be responsive to our patient's needs and concerns.

**III. I have read and understood HIPPA-PRIVACY LAW**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**We are pleased you have chosen us for your care. It is our policy to provide you with the best eye health and vision care possible. Again, welcome to our practice, we are here to be of service to you, your relatives and neighbors when the need for eye care arises.**