Thank you for choosing Fichman Eye Center

Please fill in the form below fully and completely. Questions about Race, Ethnicity and Language are required to be asked under the new Health Care Reform guidelines as is email address to comply with electronic requirements. If you have questions please feel free to ask!

Section 1: Patient Information

Name:	**Preferred Name (nickname):**
Sex:	**Date of Birth:**
Street Address (include apt # or Unit):	**Home Phone:**
City: **Zip:**	**Work Phone:** **Cell Phone:** (_____)_____ **Email: (*please enter*):**
Social Security Number: **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino or Decline to Answer	**Marital Status (circle one):** Single Married Divorced Widowed Other **Race:** American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White or Decline to Answer
How were you referred to us? ☐ Friend or Family ☐ Insurance ☐ Internet/ Website ☐ TV Add/ Commercial ☐ Saw signage/drive-by ☐ Existing patient ☐ Friend or Family (can we have their name?) _____ ☐ Other (please specify) _____	**Preferred Language (please write in if other than English):**_____ **Emergency Contact:**_____ **Emergency Number:(____)**_____

Section 2: Person Financially Responsible For This Account

Name:	**Date of Birth:**
Relationship to Patient (circle one): Self Spouse Parent **Other: _____**	**Social Security Number:**
Street Address:	**Home Phone:** **Work Phone:** **Cell Phone:** (_____)_____
City/State/Zip:	
Employer: (*please enter*)	

Section 3: Insurance Information

Initial here if there are no changes to the information below

Primary Insurance	Secondary Insurance
Name of Insurance:	**Name of Insurance:**
Name of Policy Holder:	**Name of Policy Holder:**
Policy Holder's Date of Birth:	**Policy Holder's Date of Birth:**
Relationship to Patient (circle one): Self Spouse Parent	**Relationship to Patient (circle one): Self Spouse Parent**
Employer: (*please enter*)	**Employer: (*please enter*)**

Section 4: Authorization and Acceptance

I authorize the release of any information, including records of any treatment or examination rendered to me or my child during the period of care, to third party payers and/or clinic insurance benefits otherwise payable to me. I understand my insurance may pay less than the total amount due. I understand that I am responsible for any portion of my account not paid by insurance within 60 days. **I understand as a Medicare patient Refractions are not covered.** I have no insurance or if my insurance plan has no formal agreement with the clinic or my insurance does not cover routine eye exams, I understand I am responsible for my entire account balance when services and/or materials are delivered to me. I understand and agree that if I am in default of this agreement, I will pay all reasonable & legal fees, court costs, & other costs necessary to collect the debt, including fees charged by a collection agency.

Signature: _____**Date:** _____