Welcome to Infinity Eye Care

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Nickname _____
Street _____
City _____ State_____ Zip_____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Patient's SSN _____
Date of Birth _____
Sex ❑M ❑F
Employer (or School) _____
Occupation (or Grade)_____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Were you referred to our office? ❑ Yes ❑ No
Referred By? _____
What is the major purpose of this visit?
_____

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____
Subscriber Address _____
_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____
Subscriber Address _____
_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company and not Infinity Eye Care.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Infinity Eye Care.

X_____
Patient Signature

Notice of Privacy Policy

In order to protect the privacy and confidentiality of your health information, Infinity Eye Care and their team members are requesting your permission to provide information to individuals other than yourself.

Please Identify individuals that you AGREE to allow Infinity Eye Care to communicate with regarding your healthcare or billing information via telephone, fax, or in person.

NAME:_____
RELATIONSHIP:_____

NAME:_____
RELATIONSHIP:_____

NAME:_____
RELATIONSHIP:_____

- I **AGREE** that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends, or any other person that **I have identified above.**

- I **AGREE** to be contacted by telephone, mail, or e-mail for appointment conformations, follow-up about treatments or test results, in an emergency at work, and that you may leave messages on my answering machine.

If you disagree to any of the above statements, please write **DISAGREE** beneath that statement.

I acknowledge that I have received a copy of Infinity Eye Care's Notice of Privacy Practices, which describes how my medical information is used, disclosed, and how I may access this information. I hereby authorize the physician to release any information required to process my insurance claim. I also authorize my insurance benefits be paid directly to the physician, and I understand that I am responsible for any non-covered services or goods.

PATIENT'S PRINTED
NAME:_____

PATIENT'S
SIGNATURE:_____

DATE:_____

Relationship to patient, if signed by anyone other than the patient. (Parent/Legal Guardian, Personal Representative, etc.)_____