

Advance Family EyeCare
Dr. Eldon R Repsher, Optometrist

PATIENT INFORMATION FORM

Today's Date: _____

Patient's Full Name: _____ Date of Birth: _____

Address: _____ Social Security # _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Do you accept text messages: Y / N

Email: _____ How do you prefer to be contacted: Cell Phone / E-mail / Text

Employer: _____ Work Phone: _____

Spouse's Name: _____ Work Phone: _____

To notify In Case of Emergency? _____ Phone: _____

Race: white black hispanic asian indian other _____ MALE FEMALE

For Children, Please Fill out This Section:

Father guarantor?

Mother guarantor?

Name: _____

Name: _____

Address: _____

Address: _____

City/St/Zip _____

City/St/Zip _____

Social Security # _____ DOB _____

Social Security # _____ DOB _____

Employer: _____

Employer: _____

Phone: _____

Phone: _____

Who is PRIMARY INSURANCE under? Father Mother Self Spouse

Vision Insurance: _____ ID # _____

Medical Insurance: _____ ID # _____

Medicare # _____ Medicaid # _____

Medicare Supplement _____ Pol. # _____

(We will need to make copies of your cards)

Assignment of Benefits

I hereby assign all medical and/or vision benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advance Family EyeCare.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient record.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Patient Signature _____ Date _____

Signature of Responsible Party _____ Relationship _____ Date _____

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. The ultimate responsibility for payment to the optometrist lies with you.

Please turn this form over and complete side two