PROCTOR VISION CLINIC

New Patient Information Form- please print clearly

Today's Date: _____ **Male / Female / Other:** _____ **Pronouns:** _____

Full Legal Name: _____ **Preferred Name:** _____

Address: _____ **City, State, Zip:** _____

Social Sec #: _____ **Birthdate:** _____ **Age:** _____

Hm phone: _____ **Wk phone:** _____ **Cell:** _____

Best way to contact you: Hm Wk Cell Email **Marital Status:** Single Married Divorced Widowed **Hobbies:** _____

Occupation: _____ **Email:** _____

Can we text your cell? Y / N

Emergency Contact: _____ **Phone #:** _____

Who may we thank for referring you to us? _____

Responsible Party (if different from above)

Name of person responsible for account if not the patient: _____

Address: _____ **City, State, Zip:** _____

Hm phone: _____ **Wk phone:** _____ **Cell:** _____

Employer: _____ **Relationship to patient:** _____

Medical Insurance Information

Insurance: _____ **Group #:** _____ **ID #:** _____

Subscriber's Name: _____ **Subscriber's Last 4 of Social Sec #** _____

Patient's relationship to subscriber: Self Spouse Child Other: _____

Subscriber's Employer: _____ **Subscribers Date of Birth:** _____

Please read and sign below

We will be happy to bill your insurance for you as a *courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager or any other staff members, not with the doctor.

I acknowledge that I have completed all the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third-party payers and/or other health practitioners if needed. **Lastly, I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refund will be given. Any eyewear returns or exchanges may be subject to a restocking fee.**

X _____ Date: _____