FIRESIDE EYE CARE, P.C.
WELCOME

Welcome to Fireside Eye Care, P.C. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female #7C

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip Code

Social Security Number | Date of Birth / / | Home Phone | Work Phone | Mobile Phone

You or your parent's employer | Occupation

Employer's business address | City | State | Zip Code

Spouse or Parent(s) Name | Person Responsible for Account (Must sign at bottom)

Email Address

☐ Please check this box if you do not want email notification for appointment reminders or notification that glasses or contacts have arrived

Preferred method of communication: ☐ Email ☐ Telephone ☐ Postal

Preferred Language: #7C ☐ English ☐ Spanish ☐ Other

Ethinicity: #7C ☐ Hispanic or Latino ☐ Native Hawaiian / Other Pacific Island ☐ NOT Hispanic or Latino

Patient's Status: ☐ Single ☐ Married ☐ Full Time Student ☐ Part Time Student ☐ Employed ☐ Other

How did you hear about us? ☐ Location ☐ Insurance Bklts ☐ Yellow Pgs ☐ Referred by: ☐ Other

PRIMARY *VISION* INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip Code

☐ Male ☐ Female Insured's First Name | MI | Insured's Last Name

Patient's relationship to Insured:

Insured's Identification Number | Group Number | Insured's Date of Birth / / | ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY *MEDICAL* INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip Code

☐ Male ☐ Female Insured's First Name | MI | Insured's Last Name

Patient's relationship to Insured:

Insured's Identification Number | Group Number | Insured's Date of Birth / / | ☐ Self ☐ Spouse ☐ Child ☐ Other

Please read:

I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a service charge on all returned checks. Professional services are not refundable, and all product sales are final. Any returns that are approved may be subject to a restocking fee.

I authorize payment from my insurance to be paid directly to Fireside Eye Care, P.C. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit copy of this authorization to be used in place of the original.

Signature | Date