

Patient Information

For Office Use Only
Account# _____

Date: _____

Full Name: _____ **Birth Date:** _____ **Age:** _____

Sex: F M **Marital Status:** Single Married Other

Home Address: _____ **Home Phone:** _____
(Street)

_____ **Cell Phone:** _____
(City, State & Zip Code)

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Emergency Contact: _____ **Phone Number:** _____
(Relationship to Patient: SPOUSE PARENT GUARDIAN FRIEND)

INSURANCE INFORMATION:

Insurance Company	Membership/Subsriber #	Group #	Vision Code (For HMSA)	Subscriber Name (Insured/Sponsor Name) As it appears on your insurance card
Primary:				

Patient's Relationship to Insured/Sponsor (circle one): SELF SPOUSE CHILD OTHER

Insurance Company	Membership/Subsriber #	Group #	Vision Code (For HMSA)	Subscriber Name (Insured/Sponsor Name) As it appears on your insurance card
Secondary:				

Patient's Relationship to Insured/Sponsor (circle one): SELF SPOUSE CHILD OTHER

THE FOLLOWING STATEMENTS MUST BE REVIEWED BY THE PERSON RESPONSIBLE FOR PAYMENT:

- I understand that I am responsible for all charges not covered by my insurance plan.
- I acknowledge that full payment is required at time of service.
- I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical or vision benefits to Traci L. Schmalle, OD, LLC for any eligible services I receive at this office.
- I understand that I am responsible for any fees not covered by my insurance company.

If patient will be fit for contact lenses:

- I understand that the contact lens fitting fee is a non-refundable service charge.
- I understand that the contact lens fitting fee includes all contact lens follow-up visits performed within 3 months of the initial contact lens fitting.
- I understand that the prescribing doctor will release my contact lens prescription once I have returned for all necessary follow-up appointments. The contact lens prescription will be valid for one year from the date of the original exam.
- I understand that the contact lens fitting fee does not include services provided to treat eye infections, abrasions, trauma or any other medical conditions incurred while using contact lenses whether they can be attributed to actual contact lens use or not. Treatment of these medical conditions will be billed to my medical insurance when applicable. If I do not have any medical insurance, I will be responsible for the charges incurred.

Signature (If patient is under 18, parent or legal guardian must sign)

Date
