WELCOME TO ADVANCED EYECARE | DR. JULIE LAGODINSKI CHRISTIAN, OD

PATIENT INFORMATION

PATIENT NAME: _____ **GENDER:** MALE / FEMALE
LAST FIRST MI

DOB: ___/___/___ **SSN:** ___–___–___ **EMAIL:** _____

ADDRESS: _____
CITY STATE ZIP CODE

PREFERRED PHONE: _____ **SECONDARY PHONE:** _____
HOME / WORK / CELL HOME / WORK / CELL

GUARDIAN (IF UNDER 18): _____
NAME RELATIONSHIP

RACE: ___ American Indian ___ Asian ___ African American ___ Pacific Islander ___ White ___ Other

ETHNICITY: ___ Hispanic ___ Not Hispanic

MARITAL STATUS: ___ Single ___ Married ___ Other

DOMINANT HAND: ___ Right ___ Left ___ Ambidextrous

PREFERRED LANGUAGE: _____

EMPLOYER: (or school) _____ **OCCUPATION:** (or grade) _____

****A NOTE TO OUR CONTACT LENS WEARERS****

In most cases contact lenses are not considered "medically necessary" by insurance companies. Any test performed to determine or update a contact lens prescription may not be covered by most insurance plans and will be the responsibility of the patient.

PRIMARY MEDICAL INSURANCE *Many eye problems are covered by your health insurance.

Name of Insurance: _____ ID #: _____ Group #: _____

Subscriber: _____ DOB: _____ SSN: _____

Relationship to patient: _____ Phone: _____

SECONDARY MEDICAL INSURANCE

Name of Insurance: _____ ID #: _____ Group #: _____

Subscriber: _____ DOB: _____ SSN: _____

Relationship to patient: _____ Phone: _____

VISION INSURANCE

Name of Insurance: _____ ID #: _____ Group #: _____

Subscriber: _____ DOB: _____ SSN: _____

Relationship to patient: _____ Phone: _____

Medical Release Authorization & Insurance Assignment

I authorize Advanced Eyecare to submit my claims to my plan sponsor or health plan to receive reimbursement directly for services that I have received from this office. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurances status, I am ultimately responsible for the balance on my account.

I understand that Advanced Eyecare may use and disclose necessary personal health information (for example, name, address, ID#, exam information) to another party to permit Advanced Eyecare to perform administrative duties, provide me with eye care services and products, process my insurance claims and communicate with me regarding vision care services provided to me (for example, mailing of exam renders or information about services). **I can be assured that Advanced Eyecare does not sell my personal health information of any kind to a third party for such party's own use.**

I have reviewed a copy of Advanced Eyecare's Notice of Privacy Policies.

_____

PRINT NAME SIGNATURE DATE