FAMILY EYECARE CENTER

Dr. M. Briggs Bauman
Optometry

Patient Information

Name_____Sex_____
First MI Last Suffix

Address_____
Street or PO Box City State Zip Code

Primary Phone #_____ Cell or Alternate #_____ Work #_____

Communication Preference: Phone Email Text Mail May we contact you at work? Yes No

Birthdate_____ Age_____ Social Security Number_____ Marital Status_____

Spouse's Name_____ Spouse's Date of Birth_____ Spouse's SSN_____

Email Address_____

Employer (or School)_____ Occupation (or Grade) _____

Family Doctor_____ Phone #_____

If Minor, Parent/Guardian Name_____ Social Security Number_____

Parent/Guardian Address (If different from above)_____

How did you select our office? Friend or co-worker_____, Yellow pages_____, Internet_____, Other_____

Whom may we thank for referring you?_____

Acknowledgement of receipt of HIPPA –
Date:_____ I acknowledge that I received a copy of Family Eyecare Center's Notice of Privacy Practices.

_____
Patient Signature

Payment Policy and Insurance Information
Examination fees and co-payments are due at the time of service. If you have insurance coverage, we will submit your claim for you. After 30 days, we will expect **payment in full** if your insurance has not paid for your services. I will be paying by **Cash_____ Check_____ Debit/Credit Card_____.** There is a $25.00 NSF returned check fee. **A minimum of 24 hours cancellation notice is required for appointments; failure to do so may result in a $25.00 charge.**

Vision Insurance_____ Medical Insurance_____

Name of Insured_____ Insured's date of birth_____

Relationship to Patient_____ Insured's Social Security #_____
Please show all insurance cards to the receptionist.

Patient's or Authorized Person's Signature
I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Family Eyecare Center, P.C., for services rendered. I understand that I am financially responsible for charges not covered by said insurance.

_____ _____
Signature of Patient (or Guardian) Date