Lakeside Vision Patient Information Form

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ALL INFORMATION MUST BE COMPLETED BEFORE DOCTOR CAN BE SEEN

Mr. Mrs. Ms. Miss Master (*please circle one*) Patients Name:	Age:	Sex: M F	Birth date: - -
Who may we thank for referring you to us?	Social Security #:	Marital Status: (*please circle one*) Married Single Divorced Widowed	
Mailing Address:	City:	State:	Zip:
Home Telephone #:	Daytime Telephone #:	Cell Phone# Text OK? Y/N	E-mail Address:
Student: Full-Time Part-Time	Employed: Full -Time Part –Time Unemployed Disabled Retired	Employer:	Occupation:
Race: (*Please Circle One)* / Opt Out American Indian or Alaska Native/ Asian / Black or African American / Hispanic / Native Hawaiian/Other Pacific Island / White	Ethnicity: (*Please Circle One)* / Opt Out Hispanic or Latino / Native Hawaiian or Other Pacific Island / Not Hispanic or Latino	Communication Preference: Phone / Text Email / Post	

Insurance Information: A copy of all insurance cards is required for

	Medical Insurance :		
Name of Person with Insurance: Guarantor:		Employer:	
Relationship to patient:	Birth date: / /	SSN#:	Sex: M F
Mailing Address:	City:	State:	Zip:
Home Telephone #:	Daytime Telephone #:	Cell Phone#	E-mail Address:

Secondary Medical Ins. _____

Ins. Gurantor for Secondary Ins:_____ Phone:_____

Address: _____ City: _____ State____ Birth Date:_____ SSN#_____ Sex: M F

Primary Care Physician Information Required:

Primary Care Physician Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Pharmacy Name/Location: _____/_____ Phone#_____

ALL COPAYS ARE DUE SAME DAY AS SERVICE

Payment: New patients require payment in full when ordering. Exisiting patients may place a 50% deposit upon ordering with payment in full due upon dispensing. Professional fees are due at time of service. Debit Card does not require a minimum. Mastercard, Visa, American Express and Discover are welcomed. Credit cards require $25.00 minimum.

Eligibility Guarantee: I hereby certify that I am eligible for insurance coverage. I assume financial responsibility for any service that is not approved on my referral (if such form is required by my insurance carrier.) I understand I am responsible for DEDUCTIBLE, CO-PAY OR CO-INSURANCE as my insurance plan dictates. Lakeside will submit claims to your insurance carrier for you, for those plans we partcipate in. Insurance plans vary considerably and we can not predict or guarantee what part or our services will or will not be covered by your particular plan. The patient is responsible to know the rules of their health plan as we can not change our coding in attempt to obtain payment. I agree to pay in full for all services within 30 days of billing by Lakeside Vision.

SIGNATURE:_____ DATE:_____

*Print Name:*_____

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Name of Person Financially Responsible For All Billing:

_____

Signature::_____

I authorize the following person/people to have full knowledge of my medical, financial and diagnostic diagnosis information:

Name:_____ Phone #:_____ DOB:_____

Name:_____ Phone #:_____ DOB:_____

Patient Signature: _____ Date: _____

Print Name:_____