

# Sparta Family Eye Care

## Welcome Back To Our Office

Welcome to Sparta Family Eye Care. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. 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

First Name

MI

Last Name

Preferred Name

Street Address

City

State Zip

Social Security Number

Date of Birth

Home Phone - Include Area Code

Day Phone

Email Address

Guardian

Person Responsible for Account

Emergency Contact

Emergency Phone

Current Occupation :

Years

Employer

How were you referred to our office?

Who were you referred by?

Phone Book  School  Advertisement  Patient

Insurance Listing  Drive by  Other  Doctor

PRIMARY CARE PHYSICIAN

REFERRING PHYSICIAN

### PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company

Insured's First Name

MI

Insured's Last Name

### SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company

Insured's First Name

MI

Insured's Last Name

#### Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. 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.

#### Notice of HIPAA Privacy Policies:

I acknowledge I was offered a copy of David F. Merritt, O.D.'s Notice of Privacy Acts in accordance with HIPAA requirements.

Signature

Date