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 ☐ Femal

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?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

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 ar made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged t the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old ar subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paiddirectly to . I understand that will be billed as my primary insurance. I understandhat billing any secondary insuranc 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 onl 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 Pravacy Acts in accordance with HIPAA requirements.

Signature _____ Date _____