PLEASE PRINT LEGIBLY

Geneva Eye Clinic, Ltd.

Patient's Full Legal Name ______________________________

Social Security # __________ **Date of birth:** ________ **Age** _____ **Male or Female** (circle one)

Address ____________________ **City** ____________ **State** ______ **Zip** ________

Phone# ______________ **Cell #** ______________ **Work #** ______________

E-mail Address __________________ **Marital Status:** Married ☐ Single ☐ Divorced ☐ Widow ☐

Ethnicity: (Select one) **Hispanic/Latino** ____ **Non Hispanic/Latino** ____

Race: (Select one) **White** ____ **Black or African American** ____ **Alaska Native** ____ **Asian** ____
American Indian ____ **Native Hawaiian/other Pacific Islander** ____ **Other** ____ **Decline to answer** ____

Primary Care Physician ____________________ **Phone #** ______________

Referred By ____________________ **Phone #** ______________

Endocrinologist/Diabetic Dr. ____________________ **Phone #** ______________

Emergency Contact ____________________ **Phone #** ______________

Primary Insurance Name ______________

Subscriber's Name ______________

Subscriber's Date of Birth ______________

Subscriber's Social Security# ______________

Secondary Insurance Name ______________

Subscriber's Name ______________

Subscriber's Date of Birth ______________

Subscriber's Social Security# ______________

Preferred Pharmacy: ______________

Phone# ______________

Address ______________

City __________ State _____ Zip ________

Employer ______________

Occupation ______________

Phone # ______________

Address ______________

City __________ State _______ Zip ________

SELF PAY PATIENTS: WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

MANAGED CARE PATIENTS: Due to a great variability in plans, we frequently do not know what benefits you or your employer have chosen. It is your responsibility to determine what services are covered in your individual plan prior to receiving services. Your insurance company may consider the refraction "routine vision" and/or a "non-covered service". This means you would be responsible for payment of the refraction fee. We will make every attempt to assist you where possible. **Your insurance company will determine the reimbursement and you will be responsible for payment of any co-payments, deductibles or non-covered services.** If you have a HMO plan, you are responsible for getting a referral from your primary care physician for **EACH** visit. If you have a POS plan, and self-refer (do not have a referral from your PCP) you may be subject to reduced reimbursement according to your plan.

I request that payment of authorized insurance benefits, including Medicare, Medicaid, Medigap or any other **accepted** insurance, be made either to me or on my behalf to Geneva Eye Care, Ltd. for any services provided to me by its doctors or suppliers. I authorize any holder of medical information about me to release to my insurance companies any information needed to determine these benefits or the benefits payable for related services. A Photostat of this signature shall be as valid as the original.

Signature (Patient or Guardian if minor): ______________________________

Relationship to Patient (if other than self): ______________________________

Today's Date: ____________________