

Salutation Preferred  Mr.  Mrs.  Ms.  Miss  Dr.  Sister  Father/Reverend  \_\_\_\_\_

Name \_\_\_\_\_ Sex M F

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Used to verify coverage and authorize procedures)

Marital Status  Single  Married  Separated  Divorced  Widowed

Spouse's Name \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Optometrist \_\_\_\_\_

Contact Information

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell/Other ( ) \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_

Is it allowable to leave messages for you at home or on cell numbers?  No  Yes

Physical Address

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing / Correspondence Address (if different from physical address)

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Alternate Address  Winter  Summer  Parent  Power of Attorney  \_\_\_\_\_

Name (if different than patient's name) \_\_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell/Other ( ) \_\_\_\_\_ - \_\_\_\_\_

Is it allowable to leave messages about you at these alternate contact numbers?  No  Yes

Work Information

Are you retired?  No  Yes Are you on disability?  No  Yes

Are you employed?  No  Yes

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

If we ever need to contact you at work, is this allowed?  No  Yes

Is it allowed to leave messages for you at work?  No  Yes

## Insurance Information

- Are you enrolled in a Hospice?  No  Yes
- Are you currently living at a Skilled Nursing Facility?  No  Yes
- I do not have insurance. I am responsible for all bills.
- Someone else is responsible for my bills. Provide alternate address information on page 1 of this form.
- Parent  Power of Attorney  Other \_\_\_\_\_

I have the following insurance(s). Present your insurance card(s). We will photocopy and keep on file.

**Please provide ID, Group, and Company information.**

**Who is the Policy Holder?**

1 ID# \_\_\_\_\_ Group # \_\_\_\_\_  Self  Spouse  Parent

Company \_\_\_\_\_

Address \_\_\_\_\_

2 ID# \_\_\_\_\_ Group # \_\_\_\_\_  Self  Spouse  Parent

Company \_\_\_\_\_

Address \_\_\_\_\_

3 ID# \_\_\_\_\_ Group # \_\_\_\_\_  Self  Spouse  Parent

Company \_\_\_\_\_

Address \_\_\_\_\_

**Vision Insurance** (non-medical)

ID# \_\_\_\_\_

- Vision Service Plan / Cigna Vision  
 Anthem Vision Unicare  
 Superior Vision

**Policy Holder**

Self  Spouse  Parent

**Policy Holder is spouse or parent – Provide the following information**

Name \_\_\_\_\_

SS / ID # \_\_\_\_\_ DOB \_\_\_\_\_

**Please note . . .**

- 1) Eye Center of Central Maine bills insurance or responsible party per insurance regulations.
- 2) The patient may be responsible for any of the following as determined by their insurance: copay, coinsurance, deductible, any non-authorized services (no referral on file), any service determined by insurance to be excluded from coverage or cosmetic in nature.
- 3) The patient may request at any time that the practice not bill their insurance by contacting the office in person or by certified letter.
- 4) **Patients with Medicare Part B:** If requesting an update to your eyeglass prescription we do a **refraction**. This test is considered **routine** and is not covered by Medicare Part B.

**Please choose how you want us to handle bills for services (consignment of benefits). . .**

- Bill my insurance.** Insurance payment for services will come directly to the practice.
- Do not bill my insurance.** I will be responsible for all services and bill on my own.

Please sign \_\_\_\_\_ Date \_\_\_\_\_

**Signature for consignment of benefits expires 12 months from today.**