

Frisco Eye Associates

Welcome To Our Office

Welcome to Frisco Eye Associates. Thank you for choosing us for your eye care 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 and bring this paperwork to your scheduled appointment. If you have any questions, please do not hesitate to call our office.

Circle One: Mr. Mrs. Miss Ms.
Male Female

First Name MI Last Name Date of Birth Home Phone

Street Address City Zip Code

Social Security # Drivers License Employer Work Phone

Email Address Person Responsible for Account

What is the main reason for today's exam? _____ When was your last exam? _____

Do you currently use: **Glasses?** Full Time Part Time Distance Near (circle one)

Contact Lenses? Yes No (circle one)

How were you referred to our office? _____

If referred by patient or doctor, please name _____

VISION INSURANCE INFORMATION:

Name of Vision Insurance Address of Insurance Company

Insured's First Name MI Insured's Last Name

Insured's Identification Number Insured's Group Number Insured's Date of Birth

What is your relationship with the Insured Party? Self Spouse Child Other (circle one)

MEDICAL INSURANCE INFORMATION:

Name of Medical Insurance Address of Medical Insurance Company

Insured's First Name MI Insured's Last Name

Insured's Identification Number Insured's Group Number Insured's Date of Birth

What is your relationship with the Insured Party? Self Spouse Child Other (circle one)

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 materials 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.

Signature

Date