PATIENT AND INSURANCE BENEFITS INFORMATION FORM

PATIENT'S NAME_____

DATE OF BIRTH_____/_____/_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE NUMBER (circle) CELL / WORK / HOME:_____

ALTERNATE PHONE NUMBER C / W / H_____

EMAIL (optional)_____

PATIENT'S MARITAL STATUS (circle): SINGLE / MARRIED / DIVORCED / WIDOWED

VISION INSURANCE COMPANY_____

POLICY HOLDER'S NAME_____

POLICY HOLDER'S DATE OF BIRTH: _____/_____/_____

POLICY HOLDER'S EMPLOYER_____

Occupation_____ Hobbies/activities_____

How many hours a day are you? On computer_____ Outside_____ Drive_____

Do you wear sunglasses? Y / N Is new eye wear technology important to you? Y / N

Are you considering purchasing glasses, sunglasses or contact lenses today? Y / N

Would you like information on LASIK (laser vision correction)? Y / N

Who may we thank for referring you to our office?_____

PATIENT HEALTH HISTORY FORM

FAMILY PHYSICIAN_____OFFICE_____
LAST EYE EXAM_____YEARS OFFICE_____

Please explain if you ever had ***EYE*** related infections, diseases, injuries or surgeries
_____
List any Medications you are ***ALLERGIC*** to_____
List ***MEDICATIONS*** you are taking presently: NONE_____
_____
_____
_____

Please ***CIRCLE*** any of the following you presently experience or have been diagnosed

EYES: headaches migraines blurred vision poor night vision glare
light sensitivity loss of vision (temporary or permanent) double vision tired eyes
dryness itching burning sandy/gritty excess tearing mucous discharge
redness eye pain/soreness stye(s) flashes of light floaters (floating spots)
cataracts glaucoma macular degeneration lazy eye/crossed eyes
OTHER_____

SYSTEMIC: diabetes (yr. diagnosed_____) high blood pressure
high cholesterol heart problems asthma breathing problems arthritis
seasonal allergies sinus issues smoker OTHER_____

FAMILY HISTORY: None known_____
cataracts glaucoma macular degeneration retinal detachment blindness
lazy eye diabetes high blood pressure heart problems thyroid condition
Is there anything else you think is important for the doctor to know? Please explain:

_____

SOLBERG EYE CARE FINANCIAL POLICY

Thank you for choosing Solberg Eye Care as your ocular healthcare provider. We are committed to your treatment being satisfying and successful. The following is a statement of our Financial Policy which we require you to read, agree to and sign prior to treatment.

Due to the fact that all insurance companies, policies and plans vary, it is our policy that the patient is responsible to know their insurance coverage/plan. This includes co-pays, deductibles, pre-authorization, referrals and limits on reimbursement. Our staff will be more than happy to assist you in obtaining the above information (we usually obtain this information before you arrive for your examination). We are not responsible if we are given inaccurate information from you or your insurance company.

The patient/responsible party is responsible for any balance not covered by their insurance. Some insurance companies have time limits to file claims so it is very important that you provide us with complete and accurate information in a timely manner. As a courtesy to our patients, in most cases, we will file claims to your insurance company for you. We reserve the right to assess finance charges on balances outstanding for over 60 days.

Co-pays are expected to be paid at the time of service. If a patient does not have insurance, payment at the time of service is required and a 50% deposit on products is also required, with the remaining balance to be paid at the time of pick-up.
All glasses are custom orders and sales are final.

Payments can be made by cash, check or credit card (MasterCard, Visa, Discover or American Express).

Thank you for trusting Solberg Eye Care for your ocular needs.

I have read, understand and agree to the Financial Policy as stated above. I assign directly to SOLBERG EYE CARE all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize SOLBERG EYE CARE to release all information necessary to secure payment of benefits (under HIPPA guidelines). I authorize the use of this signature on all my insurance submissions.

_____ _____/_____/_____

(signature of responsibility party) (date)