WELCOME

PLEASE COMPLETE BOTH SIDES OF THE QUESTIONNAIRE BY FOLLOWING THE THREE EASY STEPS IN BLACK INK.

Step 1 PATIENT REGISTRATION

Patient _____

Address _____

_____

City State Zip

Home Number _____

Work Number _____

Cell Number _____

Email Address _____

Sex ☐ M ☐ F Birthdate _____

Social Security Number_____

Occupation_____

Employer _____

Employer Address_____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Phone Number: (H) _____

(W) _____

Step 2 INSURANCE

Who is responsible for this account?

_____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Company _____

Group Number _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Birthdate _____

Relationship to Patient _____

Insurance Company _____

Group Number _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Ridgeland Eyecare Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Ridgeland Eyecare Center, Inc. for services furnished me by Ridgeland Eyecare Center, Inc. I authorize my holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form**, or elsewhere on other approved claim forms or electronically submitted claims, **my signature authorizes releasing of the information to the insurer or agency shown**. In Medicare assigned cases. The physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Step 3 MEDICAL HISTORY QUESTIONNAIRE

MEDICATIONS/ALLERGIES

- _____
- _____
- _____

Allergies _____

Pharmacy Name: _____

PRIMARY CARE PHYSICIAN INFORMATION

Name_____

Address_____

_____

Phone Number _____ **FAX**_____

Location: _____

Describe all illness, injuries, and surgeries: _____

_____