Family Vision Care

Oxford

Jeffrey W. Collins, O.D., M.S.

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Patient Information

Date__________________

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name_______________________________________SS#____________________Driver's Lic #________________
MISS MS. MRS. MR. DR. (PLEASE CIRCLE)

Home(Permanent) Address______________________________City____________________State_____Zip_______

Birthdate____Age__________SEX: M F

Home phone #_____________________Work phone #__________________ Cell phone #_____________________

eMail Address____FAX phone #_____________________

Your or your parent's employer______________________________Occupation______________________________

Business Address___________________________________City_____________________State______Zip______

If you are a student, name of school/college________________________Grade____City_______________State_____

Whom may we thank for referring you to our office?____

Name of Relative_________________________Address______________________________Phone #____________

Responsible Party

Name of person responsible for this account?_________________________________Relationship to patient_________

SS#_____________________Driver's Lic #____________________________Phone #_______________________

Address______________________________________City______________________State_____Zip__________

Name of employer____Work phone #___________

Insurance Information

Name of insured____________________________Birthdate_____________Relationship to patient_______________

Social Security #________________Name of employer_______________________Insurance Co._________________

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured____________________________Birthdate_____________Relationship to patient_______________

Social Security #____________________Name of employer_____________________Insurance Co._______________

Authorization

Please circle payment choice: Cash Check VISA/MasterCard Discover Vision Care Insurance Other (Please Specify)

Full payment due upon completion of services.

For your convenience, we accept VISA, MasterCard, and Discover.

Accounts 30 days past due subject to a rebilling fee of 2.0% (min. $2.50) per month.

As a courtesy, we will bill your vision care insurance for you. However, we are not responsible for collecting your claim or negotiating settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy.

I authorize the optometrist to release any information acquired in the course of examination or treatment for insurance purposes. I acknowledge that I am responsible for non-covered services. I authorize and request my insurance company to pay directly to the optometrist insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian____Date________________

(Continued on reverse side)