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MODERN OPTOMETRY

Patient Information

Patient Name: _____
Date of Birth: _____
Email: _____
Address: _____
Phone Number: Home_____Cell_____
Social Security #: _____
Marital Status: _____

Employer: _____
Occupation: _____
List Special Needs: _____
Primary Language: _____ Race: _____
Ethnicity: _____
Mother's Maiden Name: _____

Insurance/Billing Information

Name of Primary Insured: _____
Primary Insured Date of Birth: _____
Insured Social Security #: _____

Assignment of Insurance Benefits

I, the undersigned, have insurance coverage with _____ and assign directly to Modern Optometry all vision and/or medical benefits, if any, otherwise payable to me for services rendered. I authorize the release of my medical records to/from Modern Optometry. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date_____ Signed _____

HIPAA Compliance

I acknowledge Modern Optometry has presented a copy of their privacy policies.

Date_____ Signed_____

Please provide us with your insurance card(s) so we can make copies. Thank You!!