Date_____ Acct#_____

PATIENT INFORMATION

Name_____ M / F

Address_____

City_____State_____Zip_____

Preferred Phone_____

Cell/Work Phone_____

DOB_____SSN_____

Email_____

Place of Work_____

Hobbies_____

Race (circle one) White American Indian
Hispanic African American Asian Other

Spouse or Guardian (if applicable)
May we speak with this person about your care? Y / N

Name_____

Phone_____

Emergency Contact (outside the home):
May we speak with this person about your care? Y / N

Name_____

Relation_____Phone_____

How did you hear about Hummel Eye Associates?

_____

PHYSICIAN AND PHARMACY

Primary Care Physician_____

Referring Doctor_____

Preferred Pharmacy_____

Pharmacy Phone/Address_____

_____ I hereby agree to treatment by the
(*initial here*) physicians and/or staff of this practice.

INSURANCE INFORMATION

Primary Medical_____

Subscriber: Self Spouse Parent
Name of
Policyholder_____

Insured DOB_____SSN_____

Secondary Medical_____

Secondary Subscriber: Self Spouse Parent
Name of
Policyholder_____

Insured DOB_____SSN_____

Vision Insurance_____

Subscriber: Self Spouse Parent
Name of
Policyholder_____

Insured DOB_____SSN_____

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for any charges not covered by my plan benefits. It is my responsibility to know my plan benefits. In some cases exact benefits cannot be determined until the insurance company receives the claim; at which time I will be billed the remainder of the charges. I understand that I am responsible for the entire balance of the bill if the submitted claim or any part of it are denied for payment. By signing this form I am accepting financial responsibility as explained above for all payment of medical services received. I authorize the disclosure of my medical information and medications to other physicians involved in my care.

X_____
Signature Date

Refraction is a non-covered service by most medical insurances. This is the part of the examination which determines the prescription for glasses or contact lenses. This test also allows the doctor to assess how well a patient is capable of seeing, which is often necessary in determining a treatment or surgical plan. By signing below, I understand that:
THE FEE FOR THE REFRACTION IS $30 AND IS DUE AT THE TIME OF SERVICE.

X_____
Signature Date

Co-pays, Deductibles and Refraction Fees are due the day of service.