Patient Information

Patient Name _____ Birth Date _____/_____/_____
(Last) (First) (MI)

Billing Address _____
(Street) (City) (State) (Zip Code)

Home # _____ Mobile # _____ Gender: M F Marital Status: S M W D

Email Address _____ Soc Sec # _____-_____-_____

Employer _____ Phone # _____

Emergency Contact Name: _____ Phone # _____

Primary Care Physician _____ Family Eye Doctor _____

Pharmacy _____

Complete if under 21 or a student

Guarantor _____ Employer_____

Address _____

Soc Sec #_____-_____-_____ Birth Date ___/___/____ Hm #_____ Work#_____

How Did You Hear about Us? (Please mark all that apply)

- ❑ Web Search
- ❑ Family/Friend
- ❑ Primary Care Provider
- ❑ Employer/Health Fair
- ❑ Insurance Company
- ❑ Health/Employer Fair
- ❑ Emergency Rm/Urgent Care
- ❑ Optometrist
- ❑ Print Ad
- ❑ Other_____

Insurance Information

It is your responsibility to know what your insurance covers, and its coverage requirements. If your insurance requires a referral, and you do not have one, you will be responsible for payment of any charges incurred.

Primary Ins _____ Policy# _____ Group# _____

Policy Holder _____ DOB_____

Secondary Ins _____ Policy# _____ Group# _____

Policy Holder _____ DOB_____

Consent to respond to patient initated emails:

I consent to have MFEC physicians and staff communicate with me via the email. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between MFEC or staff and me may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

_____
Initial

PLEASE READ AND SIGN BELOW

I understand that regardless of my insurance status, I am solely responsible for payment of any professional services including diagnostic testing rendered to me, or on my behalf, whether or not paid by my insurance company. I request that payment of authorized Medicare benefits be made to MFEC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. **Your insurance may not pay for the refractive portion of a medical eye exam**.

Signature of Responsible Party _____ Date _____