Welcome To Our Office

In order for Moman's EyeCare to serve you better,
please verify that the following information is accurate.

Patient ID:

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Cell Phone | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone | Who were you referred by?

What is your race?

○ African-American ○ Multi-Racial (Please Specify)
○ American Indian ○ Native Hawaiian
○ Asian ○ Caucasian
○ Hispanic / Latino ○ Other

Please list any immediate family members that are patients below.

VISION INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

MAJOR MEDICAL INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. There will be a service charge on all returned checks. Late Fees will be assessed on all accounts over 60 days.

Payment from my insurance is to be paid directly to Moman's EyeCare. I understand that my primary insurance company will be billed. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

In accordance with HIPAA Regulations, a copy of ***Moman's Privacy Policy and Practices*** has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

My signature below acknowledges my receipt and acceptance of the Privacy Policy and Practices of Moman's EyeCare.

Signature | Date