Mission Optometry

Today's Date:_____

PATIENT INFORMATION

Last Name_____

First Name_____MI_____

Street_____

City_____

State_____Zip Code_____

Cell Phone_____

Home Phone_____

Work Phone_____

Patient's SSN_____

Employer/School_____

Occupations/Grade_____

Spouse/Parent's Name_____

Spouse/Parent's Workplace_____

Patient Date of Birth_____Age_____

Sex: Male Female

Email Address_____

Whom should we notify in case of an emergency?

_____

(Name) (Telephone) (Relationship)

VERY IMPORTANT!

Whom may we thank for referring you to our office?

Name of friend or relative?_____

If not referred, how did you choose our office?

- ☐ Another Dr._____
- ☐ Insurance Company
- ☐ Returning Patient
- ☐ Saw Sign/Building
- ☐ Yellow Pages
- ☐ Web Page
- ☐ Other_____

INSURANCE INFORMATION

Vision Insurance_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

Primary Medical Insurance_____

Dr.'s Name_____

HMO_____PPO_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

I understand that I am responsible for any charges not covered by my medical or vision insurance:

Payment is expected at time services are provided. We accept cash, check, MasterCard, Visa and Discover. Payment in full is required on all materials ordered.

I authorize payment to Mission Optometry and/or Robert J. Joyce, O.D., APC for all benefits now due or becoming due under my Medicare or group insurance policy for the services that have been rendered.

I authorize the release of my (or my child's) medical records as deemed necessary by the staff of Mission Optometry to a Medical Provider or on the request from a Medical Provider. I hereby acknowledge receipt of a copy of my Patient Health Information Privacy Policy.

At Mission Optometry we do Retinal Photography to screen for eye disease on <u>ALL</u> patients. The patient's portion of this service is $10.00.

_____

(Patient/Parent or Guardian Signature) (Date)