Welcome To Our Office

Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Last 4 Digits of SS# _____ Date of Birth _____ Home/Primary Phone _____ Work Phone _____ Cell Phone _____ Text Messages ☐ Yes ☐ No

Email Address _____ Spouse/Parent/Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____ Pharmacy Name & Location _____

How were you referred to our office?

☐ Current Patient ☐ Phone Book ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

People we are able to speak to regarding your care:

1. Name _____ Relationship _____
2. Name _____ Relationship _____
3. Name _____ Relationship _____

Contact Notification Options:

Please check the following phone/email options that we are allowed to leave a detailed message regarding your appointment, results, contacts lenses and or glasses. _____ Home _____ Work _____ Cell _____ Email

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 material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. 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.

HIPPA Privacy Practices: I acknowledge that I have the option of receiving the White Bear Eye Clinic & Optical's UPDATED Notice of Privacy Practices.

Signature _____ Date _____

Race

☐ Native American Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian/other Pacific Islander
☐ Other Race
☐ White
☐ Refuse To Specify
☐ Not Disclosed

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English

Height ft in cm/m ○ ft in ○ cm ○ m **Weight** ○ lbs ○ kg

Clinical Summary

This is a listing of your history based on your exam today.
Let us know if you wish to have a copy.

Contact Lens Exam, Follow-up Care and Instruction

Contact lens fitting, follow-up care and instruction have separate fees from a routine eye exam.

A complete eye exam as defined by insurance companies includes a refraction to assess the need for corrective lenses, an eye health examination, including a glaucoma test and dilated retinal examination where indicated. It does not include any assessment of impact of contact lens wear, measurements or fittings of contact lenses, progress evaluations or on-going management care for contact lens patients.

Unless contact lens coverage is specifically noted in your insurance plan, your insurance company will not pay these fees:

☐ For **FIRST-TIME CONTACT LENS WEARERS** the fee is between $96 and $168 depending on the type of lenses fitted. This fee includes the initial contact lens fitting and instruction, diagnostic contact lenses and any contact lens related visits for one full year. *Fee is higher for first-time wearers.*

☐ For **CURRENT CONTACT LENS WEARERS** the fee is between $55 and $106 depending on the type of lenses fitted. This will renew your contact lens prescription and cover any contact lens related visits for one full year.

Please check the appropriate box below:

☐ I understand the above-mentioned fees and wish to have my Corneal Evaluation and/or Contact Lens Fitting and instruction done by White Bear Eye Clinic today.

☐ I wish to return at a different time to have any Corneal Evaluation and/or Contact Lens Fitting and Instruction.

☐ I do not wish to have any Corneal Evaluation and/or Contact Lens Fitting and instruction done by White Bear Eye Clinic. I understand my contact lens prescription will not be renewed.

You will also be entitled to a 15% discount on any complete eyeglass purchase (no other discounts or insurance apply). You are also entitled to $50 off any pair of plano sunglasses (no other discounts or insurance apply).

PLEASE BE AWARE, CONTACTS PURCHASED ARE NOT RETURNABLE.

Signature:_____**Date**_____
(If you are under 18, parental consent is required.)

Form Udpated 9/17/13