Acct No.
Office Use

PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION

Date of visit: _____

Name: _____ Sex: _____ Date of Birth: _____ SS#: _____
(First) (Last)

Mailing Address: _____ City: _____ ST: ____ Zip Code: _____

Street Address: _____ City: _____ ST: ____ Zip Code: _____

Daytime Phone: _____ E-mail: _____

Primary Care Physician: _____ Address: _____ Phone: _____

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN SELF)

The parent, guardian, or adult who accompanies a child/patient to their appointment will accept full responsibility for any charges incurred by the child/patient.

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____ City: _____ ST: ____ Zip Code: _____

SS#: _____ Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT/NEXT OF KIN

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____ City: _____ ST: ____ Zip Code: _____

Daytime Phone: _____

We recognize the importance of receiving a call back in a timely manner. In order for us to effectively and efficiently deliver information to you when you are unavailable, we request your permission to give information to an authorized designee. Please check the applicable boxes below and list the name of a person or persons that we may speak with if necessary.

I authorize Spindel Eye Associates to leave any message on my:
Please check:

Answering machine ☐ Cell phone voice mail ☐

I authorize Spindel Eye Associates to leave a message with or speak to: Name: _____ _____
(Print Name) (Relationship)

regarding any information that needs to be relayed to me. Please list any exceptions or instructions: _____

All professional services rendered are charged to the patient. **Patients are responsible for providing the correct medical insurance and vision plan information at the time of service. Spindel Eye Associates will not bill after the fact if the insurance information we receive is not valid.** We will complete the necessary forms to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If a referral is required by your Insurance Company, it is your responsibility to obtain that REFERRAL from your Primary Care Physician for services as required under your Insurance Company contract.

I hereby authorize SPINDEL EYE ASSOCIATES, P.C. to furnish information to insurance carriers and I authorize insurance benefits to be made either to me or on my behalf to SPINDEL EYE ASSOCIATES, P.C.

I acknowledge that the New Patient Information Folder has been given to me and my questions answered.
I acknowledge that the Routine Eye Exam or Medical Exam Notice has been given to me and my questions answered.
I acknowledge that the Refraction Notice has been given to me and my questions answered.
I acknowledge that the Financial Policy has been given to me and my questions answered.
I acknowledge that the Patient Privacy Notice (HIPAA) has been given to me and my questions answered.

_____ _____ _____
Date Patient/Guarantor Signature Printed Name