PATIENT INFORMATION
(PLEASE PRINT)

Today's Date: _______________ Referred By: ______________________________

Name: ____ Phone (Hm/Cell): ___________________________

Address: _______________________________________ City: ________________State: _____ Zip: ______

Birth Date: _____________________ Social Security #: ___________________ Last Eye Exam: ________

Occupation: _______________________ Employer: ______________________ Phone: ________________

Name of Medical Doctor: __________________ Dr.'s Phone: _________________ Last Exam: _________

Email:____________________________________

-.-

Race: ___White ___Black ___Hispanic ___Asian ___Indian ___Other:__________

-.-

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

-.-

Emergency Contact:

Name: _________________________ Address: ___________________________ Phone: _______________

-.-

Pharmacy Name:________________________________ Phone Number:____________________________

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PAYMENT IS DUE WHEN SERVICES ARE RENDERED

Preferred Method of Payment:

____ Cash/Check ____ Visa/Master Card ____ Care Credit

I authorize release to my insurance company, referring physicians or other groups, any information required for services provided and I authorize payment of medical benefits to Dr. Horace Deal, O.D.
I also understand that I remain responsible for any and all charges not met by the insurance company. Accounts more than 30 days past due may be subject to finance charges. If my account should become in Default, then I agree to pay all cost of collection including but not limited to: court costs, attorney's fee, and collection agency fees.

Signature: _________________________ Date: ____________________

Office Staff: _________________

Insurance Information

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Professional Eye Care of Statesboro accepts most insurance plans in both categories: 1) Vision plans (such as VSP, EyeMed and others) 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision Plans only cover routine vision Wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- **Refraction and contact lenses fitting may not be covered by your insurance.**
- Medical insurance must be used for medical eye care(Problem visits, Visual Fields, etc).
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expenses.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract. It is the policy of Vision Source/ Professional Eye Care of Statesboro to file the Insurance presented the day of service. Since we only have access to the information the patient provides us regarding coverage we will file using the insurance information given.
- It is the patient's responsibility to make sure that we have the correct insurance on file. Please keep us updated and current on any changes in your insurance.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

My Current Insurance Coverage

Name of Primary_____**Primary Date of Birth** _____

Primary Insured Social Security Number:_____

Relationship to Insured: Self Spouse Child Other:_____

Medical Insurance _____

Vision Insurance _____

I have read and accept these policies. The insurance listed above will remain in effect until I update with any changes.

_____ _____

Patient signature (Parent if child) Date

Office Staff: _____