Arkansas Eyecare Specialties

Welcome to Arkansas Eyecare Specialties. Thank you for choosing us for your eyecare and eyewear 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.

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

First Name _____ MI _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account (Must sign at bottom) _____

School Name _____ ☐ **Mr.** ☐ **Ms.** Teacher's Name _____ Grade _____

What is the main reason for today's exam ? _____ When was your last exam ? _____

How were you refered to our office?

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

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

Primary Insurance Information

Name and Address of Primary Insurance Company _____

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

Secondary Insurance Information

Name and Address of Primary Insurance Company _____

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

Patient Relationship to Insured

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____ ☐ 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 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.

Signature _____ Date _____