4637 Hedgcoxe Road
Suite #108
Plano, TX 75024
972.596.2224

PATIENT INFORMATION

PATIENT

NAME: LAST _____ FIRST _____ M.I. _____ AGE _____

BIRTH DATE _____ SOCIAL SECURITY # _____ MARITAL STATUS _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ EMAIL ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

COMMUNICATION PREFERENCES (PLEASE CHECK ALL THAT APPLY): ☐ EMAIL ☐ POSTAL MAIL ☐ TELEPHONE ☐ TEXT MESSAGING

IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE

VISION INSURANCE COMPANY _____

NAME OF INSURED: LAST _____ FIRST _____ M.I. _____

BIRTH DATE _____ SOCIAL SECURITY # _____ RELATIONSHIP TO PATIENT _____

PRIMARY MEDICAL INSURANCE COMPANY _____

PLEASE LIST ANY ADDITIONAL COVERAGE, SUCH AS SUPPLEMENTAL INSURANCE, ON THE BACK OF THIS FORM AND PRESENT CARDS TO THE FRONT DESK BEFORE YOUR APPOINTMENT.

HOW DID YOU HEAR ABOUT US?

☐ INSURANCE COMPANY ☐ MARKETING MAILER ☐ WALK-IN PATIENT ☐ YELLOW PAGES ☐ REFERRAL ☐ INTERNET

REFERRED BY: _____ INTERNET SOURCE: _____ OTHER: _____

FINANCIAL ACKNOWLEDGEMENTS

I authorize payment for my vision or medical benefits to go directly to Rosemore Eye Care. I agree that if my insurance carrier, employer, or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. I acknowledge that I have read the "Notice of Patient Financial Responsibilities" located at www.RosemoreEyeCare.com; if I have not read it yet I will request a copy now. As the Patient, or the Patient's Authorized Representative for the purpose of signing this document, I hereby accept its terms. **Authorizations obtained at the time of service do not guarantee payment and any denied services will be balance billed to the patient.**

CONSENT TO TREATMENT

Rosemore Eye Care is licensed to provide both Routine Eye Exams and Medical Eye Exams. Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings, or a condition found during the course of the exam, the doctor may find it necessary to move from a Routine Eye Exam to a Medical Exam as well as order additional tests. The doctor will notify you during the course of the exam if it is determined that a Medical Exam is required. When a Medical Exam is required, be advised it is not a covered item under your Routine Eye Exam benefits through your Vision Insurance Plan. Medical Exams are billed through your Major Medical Carrier and are subject to their specific Copays, Deductibles, and Co-Insurance, which will be due at the time of service. **In the event I do not wish the Doctor to proceed with a Medical Examination, I understand it is my responsibility to immediately inform the Doctor so that he can refer me out to the appropriate Doctor or Specialist.**

PATIENT/GUARDIAN SIGANTURE: _____ DATE: _____