

## Precision Optics Welcome To Our Office

Welcome to Precision Optics. 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.

Mr.  Miss  Mrs.  Ms.  Male  Female

\_\_\_\_\_  
 First Name MI Last Name Preferred 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

\_\_\_\_\_  
 Emergency Contact Emergency Phone

How were you referred 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 City State Zip

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 Patient Status  Single  Married  Other  
 Self  Spouse  Child  Other  Full Time Student  Part Time Student  Employed

**SECONDARY INSURANCE INFORMATION**

\_\_\_\_\_  
 Name and Address of Secondary Insurance Company City State Zip

M  F  \_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
 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 Jill Smith, O. D., L. L. C.. 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 Policy:**

I have read and/or received Precision Optics Notice of Privacy Practices.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date