Gilbert Family Eye Center

New Patient intake form

Today's date_____

Last Name_____ First Name_____ Middle_____Male/Female

Address_____ City_____ State_____ Zip_____

Telephone: Home_____ Daytime_____ Cell_____ Text? (Y) (N)

Email_____ Preferred Communication (circle) Email Phone Text

DOB (patient) _____ SS#_____ Ethnicity_____ Marital Status_____

Employment Status_____ Employer_____ Occupation_____

Vision Insurance_____ Medical Insurance_____ Member Name/ID# _____

Emergency Contact/Phone#_____ Relation to Patient_____

Primary Care Physician Name_____ Phone #_____

Emergency Contact/Phone #_____ Relation to Patient_____

As Part of your routine vision exam the following testing is recommended, by the doctors. These tests help the doctors detect and monitor the health of your eyes.

Retinal Imaging $39_____ OCT Screening $49_____

-OR-

Retinal Imaging & OCT Screening Package $59_____

Are you being seen for contact lenses or would like to be? Yes____ No_____

A contact lens evaluation is required to obtain a prescription (**this includes annual prescription renewals**) This evaluation is not covered by most insurance plans, and can range from $60 and up, depending on your prescription and lens type

PLEASE NOTE: As a courtesy we will bill your insurance carrier on your behalf; however, we are not held liable to any expenses that are not covered by insurance, and we have the right to contact you to request payment.

Acknowledgement of Receipt

I,_____have reviewed the notice of **Privacy Practices** for the office of Gilbert Family Eye Center. If I have any Questions I will refer them to the staff at Gilbert Family Eye Center.

Patient/Guardian Signature:_____ Date_____

Patient Responsibility

I,_____ understand that **I am ultimately responsible for payment** of all services provided for myself and my dependents by Gilbert Family Eye Center. I understand that if my eligibility cannot be verified, or if I do not obtain the proper referral form when required, **I will be financially responsible** for payment of all charges incurred for services rendered for me and my dependents. I authorize the payment of claims to Gilbert Family Eye Center.

Patient/Guardian Signature:_____ Date_____