WELCOME TO FAMILY VISION CARE OF KINGSTON & ELEGANT EYEWEAR!

NAME:_____BIRTH DATE:_____

ADDRESS:_____CITY:_____

STATE:_____ ZIP CODE: _____

PHONE: (H)_____ (W)_____(C)_____

WHERE DO YOU PRERER TO RECEIVE CALLS? _____

EMAIL ADDRESS: _____

SOCIAL SECURITY#:_____

MARITAL STATUS:_____ SEX: M F (PLEASE CIRCLE)

FAMILY DOCTOR:_____

EMPLOYER:_____ OCCUPATION:_____

IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU TO OUR OFFICE?

_____

HOW DID YOU HEAR OF OUR OFFICE?_____

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May we leave information on an answering machine/ voice mail? YES____ NO _____
May we leave information with another person at your residence? YES____ NO_____
May we leave information by e-mail? YES ___ NO _____

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I, the undersigned hereby grant permission to release my medical information and medical records, when necessary, and authorize payment to Family Vision Care, Inc. I understand that I am fully responsible for payment of CO-PAYMENTS, DEDUCTIBLES and ANY CHARGES NOT COVERED BY MY INSURANCE. We cannot be responsible if you are not eligible for benefits.
For MEDICARE PATIENTS, I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Family Vision Care, Inc. for any services furnished to me by my optometrist (physician) or supplier. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents to determine these benefits and payment for related services.

SHOULD YOUR ACCOUNT GO TO COLLECTION FOR NON-PAYMENT, THE PATIENT/ GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION/ATTORNEY FEES.

SIGNATURE:_____ DATE:_____