EST 1991

EYES ON MAIN

· quality vision care ·

WELCOME TO OUR OFFICE **Gene Harrison, O.D.** **Gary Few, O.D**

Date: _____

Last _____ First _____ MI ____

Date of Birth _____ Age ____ Sex M F

Street _____City _____ State ____Zip _____

Phone Number _____ Cell Number _____

Employer (or school) _____

Occupation (or grade) _____

Spouse (or Parent's Name) _____

Email Address: _____

Insurance Information:

Vision Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

Primary Medical Insurance:

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

Contract Number: _____

Family Medical/Eye History (check all that apply)

Is there a family history of any of the following: Relationship:

Blindness
Cataracts
Corneal Problems
Glaucoma
Lazy Eye
Macular Degeneration
Retinal Problems
Diabetes
Heart Disease

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Dr. Harrison/Dr. Few O.D., Notice of Privacy Practices

Date: _____

Patient Name: _____ Patient Signature: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Harrison and Dr. Few all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Certain routine services and/or materials that we feel are necessary for good health may not be covered by your insurance. You will be expected to pay for those services and/or materials in full. Should my account become delinquent and require services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for collection. I have read the above policies and agree as indicated by my signature.

PATIENT OR RESPONSIBLE PARTY DATE