ABILENE EYE INSTITUTE
NEW PATIENT INFORMATION

Name of Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Sex: Male [ ] Female [ ] ***Race: [ ] American Indian or Alaska Native, [ ] Asian, [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander, [ ] Other Race, [ ] White

***** Ethnicity : [ ] Hispanic or Latino [ ] Not Hispanic or Latino**

Language Spoken: _____ Email address if available: _____

Married: [ ] Single: [ ] Date of Birth _____ Age: _____

Social Security #: _____ ** Driver's License #: _____**

***** Federal Regulations requires us to ask you about this information to meet Meaningful Use Requirements.**

****** Please present Photo ID to receptionist.**

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Name of Spouse or Parent if a Minor: _____

Close friend or relative not living with patient: _____

Address: _____ Phone # of friend or relative_____

Name of Responsible Party (if different from above): _____

Address: _____

Home Phone: (_____)_____ Other phone: (_____)_____

Who is your Optometrist? _____ City: _____
Did he/she refer you to us? Yes_____ No_____

Who is your Family Doctor _____City: _____
Did he/she refer you to us? Yes_____ No_____

Who may we thank for referring you to us? _____

BILLING INFORMATION

Please check the appropriate type of payment and/or billing information and provide the receptionist with your insurance cards and ** government issued PHOTO ID for copying.**

PRIVATE PAYMENT: Check [ ] Cash [ ] Credit Card [ ]

I understand that I am financially responsible for all charges for services provided to me by Abilene Eye Institute.

Medicare _____ Medicare # _____
I request that payment of authorized Medicare benefits be made on my behalf to Abilene Eye Institute for any services furnished to me. Abilene Eye Institute has agreed to accept Medicare assignment. I authorize any holder of medical information about me to release to my Medicare/Medigap Supplement Insurance Company and its agents any information needed to determine these benefits payable for related services.

Medicaid _____ Medicaid # _____
Please present current Medicaid Eligibility sheet in addition to a government issued photo ID to the receptionist for verification of Medicaid benefits.

HMP/PPO _____ Insurance Company:_____
Policy Holder (if other than yourself): _____
Relationship to policy holder: _____
Policy holder's Date of Birth: _____

I hereby authorize release of medical information necessary to file claim with my insurance company and ASSIGN BENEFITS OTHEREWISE PAYABLE TO ME to Abilene Eye Institute.

***Should my insurance decline to pay for services rendered, even after obtaining a referral authorization number, I agree to be financially responsible and pay for charges incurred. In the event that my bill goes unpaid, Abilene Eye Institute (AEI) may turn my account over to a collection agency. Any fees incurred by AEI to collect on my bill will be my responsibility.**

Signature of Patient or Guardian:_____

****** RED FLAG RULE**** In compliance with the new ruling by the Federal Trade Commission (FTC), we are required to obtain from you a photo ID from a government agency (ex. Driver's license or Military ID) in order to determine a positive identification. This is to protect you, the consumer, from identity theft.**
Please cooperate with the staff in order for us to be compliant with this law. Thank you