



# PRIMARY EYE CARE CENTERS

Treatment & Management of Ocular Disease

1641 N. ALPINE ROAD SUITE 205

ROCKFORD, IL 61107

PHONE 815-397-5337 FAX 815-397-5540

WELCOME TO OUR OFFICE!

Patient # \_\_\_\_\_ Appt \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time \_\_\_\_\_

**Patient Information** **\*\*Social Security numbers are still required for insured person to pull insurances.**

Full name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Male / Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_

If married, full name of spouse: \_\_\_\_\_ Names of children in household: \_\_\_\_\_

If minor, Father: First \_\_\_\_\_ Last \_\_\_\_\_ Mother: First \_\_\_\_\_ Last \_\_\_\_\_

Date of your last Medical exam \_\_\_\_\_ PCP/ Doctor's name: \_\_\_\_\_

PCP/Doctor's Address \_\_\_\_\_ Office Phone#: ( ) \_\_\_\_\_

**Insured Party Employment Information: (needed for insurance)**

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Work Phone : ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Insurance Information: all information needed to pull insurance**

Insured Person (member): \_\_\_\_\_ Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Vision Insurance: \_\_\_\_\_ ID # (if not SSN) \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ ID # \_\_\_\_\_ Group \_\_\_\_\_

Medical Insurance phone number ( ) \_\_\_\_\_ - \_\_\_\_\_ patient email \_\_\_\_\_

**Insurance Authorization and Release of Information:**

I hereby authorize my physician(s) and his/her designee(s) to release and disclose such medical records, information, and documentation, as may be necessary or appropriate in order to process insurance claims and to obtain payment on my behalf. I also authorize the release of information acquired in the course of my examination or treatment and all information pertaining to my history and progress of my case. I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

- **ASSIGNMENT** In consideration for health care services provided to me by Primary Eye Care Centers, p.c., I here assign to my Physician(s) all of my insurance benefits for physician care and related services to which I may be entitled according to my policy of insurance with all my insurance companies.
- **WHEN INSURANCE COVERAGE IS INSUFFICIENT** In the event the insurance benefits which have been assigned hereunder to my physician(s) are insufficient to pay for all the health services provided to me, I understand that I will be fully responsible for payment of balances due (or my physician's total charge in the event the insurance benefits are not paid to my physician(s)). I also understand if payment is not made to the physician or billing company used by the physician (for services and materials submitted to insurance or not submitted to insurance) in a timely manner (60 days) and I am sent to collections, I am also responsible to pay the original fees plus any or all collection fees, lawyer expenses and court costs associated with collection of what is owed to the physician or billing company. I also understand that eyeglasses are medical devices and once ordered are non-refundable and I will be responsible for payment in full.
- **MEDICAL RECORDS** I understand that my medical records, including any alcohol or drug abuse data may be protected by Federal Regulations- 42CFR Part 2. I authorize release of my medical records including any information regarding drug and alcohol abuse.
- We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a COURTESY that we extend to our patients, **All CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

\_\_\_\_\_  
Patient name (Printed)

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian Name( Printed) (under 18)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date