DRS . DRIVER & CLARK, P.A.
GENERAL PATIENT INFORMATION

Today's Date: _____

Name: _____ **M.I.**_____ **Preferred Name or Nickname:**_____

Date of Birth: _____ **Sex:** M / F **Marital Status:** Single Married Divorced Widowed

Spouse's Name: _____

Mailing Address: _____**City/St/Zip:**_____

Primary Phone #: _____ home or cell **Other Phone #:** _____ home or cell

E-mail address: _____ **Preferred way to contact you:** _____

Occupation: _____ **Employer:** _____ **Work Phone #:** _____

How did you learn about our services &/or who can we thank for referring you to our clinic?

_____

If you are under 18 who are your parents or legal guardians?_____

PAYMENT FOR SERVICES AND PRODUCTS

Examination fees including insurance co-payments and deductibles are due on the day of the examination.
Optical orders require a **50% deposit** with the balance payable in full upon dispensing.
If you are not responsible for your own charges, who is & what is their address, phone number, and date of birth?

Name: _____Date of Birth: _____ Phone #:_____

Address:_____City, State, Zip:_____

[ ] GENERAL INSURANCE AUTHORIZATION: "RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS"

I request that any payment from my insurance benefits be made to ***Drs. Driver & Clark, P.A.*** on my behalf for services provided to me by them in accordance with this assignment. To accomplish this, I authorize the release of any medical information about me to assist in determining benefits payable for me. I understand that my signature below requests that my benefits be made directly to ***Drs. Driver & Clark, P.A.,*** and that I am responsible for items not paid for me by my insurance, such as co-pays, deductibles and non-covered services. In signing this I understand that my insurance may not cover my entire account in full and that I will be responsible for all fees not covered in this assignment.

X_____ _____
Patient Signature (or responsible party) **Date**

If insurance is carried by someone other than you, please fill out below for **the insured who carries the plan:**

Name: _____ Relationship to the patient: _____

Address: _____ City, State, Zip:_____

Date of Birth of insured: _____ Place of Employment: _____

Primary Phone Number: _____ Work Phone Number: _____

[ ] NOTICE OF EXCLUSION FOR MEDICARE BENEFITS (NEMB)

I have been informed and understand that my **Medicare** insurance will not pay for my entire health care costs and I understand that **Medicare** only pays 80% of allowable services after a deductible has been met. If I have a **Private Medicare Plan** (ex. PFFS, HUMANA, ADVANTRA) I understand that I also must pay a co-pay amount. I also understand that **Medicare** does not pay for routine eye examinations and refraction testing.

X _____ **(Initial)**