Canyon Eye

A division of The Eye Physicians, LLC

PATIENT INFORMATION

NAME: _____ **SEX**: **M** **F**

ADDRESS: _____
STREET *CITY* *STATE* *ZIP*

DATE OF BIRTH: ____/____/____ **MARITAL STATUS**: Married Single Divorced Widow

Social Security #: _____ **RACE**: _____ **LANGUAGE**: _____

HOME PHONE: (___) ___-____ **CELL PHONE**: (___) ___-____ **EMAIL**: _____

PREFERRED METHOD OF CONTACT? ☐ PHONE ☐ TEXT ☐ E-MAIL

OCCUPATION: _____ **EMPLOYER**: _____ PHONE: (___) ___-____

PHARMACY: _____ **PHONE**: _____

PRIMARY PHYSICIAN: _____ **PHONE**: _____

REFERRING PHYSICIAN: _____ **PHONE**: _____

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? _____ IF SO, WHERE: _____

PATIENT CONTACTS:

EMERGENCY: _____ RELATIONSHIP: _____

PHONE: _____

NAME: _____ RELATIONSHIP: _____

PHONE: _____

INSURANCE INFORMATION: ** *Please present your insurance card to the receptionist at each visit.***

PRIMARY INSURANCE: _____ ADDRESS: _____

POLICY HOLDER: _____ DOB: ____/____/____

POLICY/ID: _____ SS# _____

GROUP #: _____ EFFECTIVE DATE: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER: _____

SECONDARY INSURANCE: _____ ADDRESS: _____

POLICY HOLDER: _____ DOB: ____/____/____

POLICY/ID: _____ SS# _____

GROUP #: _____ EFFECTIVE DATE: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER: _____

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VISION INSURANCE:_____ ADDRESS:_____

POLICY HOLDER:_____ DOB: ____/____/_____

POLICY/ID: _____SS# _____

GROUP #: _____ EFFECTIVE DATE: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER: _____

Insurance Eligibility and Guarantee of Payment:

I understand that it is my responsibility to provide the practice with current and accurate information to include my address, telephone number, email, and insurance information at each visit.

I acknowledge that, as a courtesy, Canyon Eye Associates will attempt to verify my insurance eligibility at the time of service but does not guarantee coverage. Some immediate payment may be expected at the time of service. This may include co-pay and/or additional payment if this practice determines that the cost of some or all services will not be covered at today's visit. _____

Canyon Eye Associates will submit a claim for reimbursement of services received to the insurance carrier I have provided. I understand that I am responsible for the payment of services rendered if not covered in full by my health insurance or due to invalid insurance information. I accept responsibility for knowing and understanding my insurance carrier(s) plan coverage_____

Self-Pay Patients: If you are a patient with no medical insurance and pay for services out of pocket, Canyon Eye Associates will require payment at the time service, unless payment arrangements were made prior. _____

I agree that this authorization is valid until rescinded in writing or replaced by one at a later date.

Patient Signature:_____Date:_____

Responsible Party (if any):_____Relationship: _____

Responsible Party Signature:_____Date: _____

Notice of Refraction Fee:

Refraction is the test the doctor or technician will perform to determine if you need a new prescription for corrective lenses and is not considered part of your routine medical eye exam. This test is NOT COVERED by most health insurance plans. If you decide to get a refraction done at your visit, you will be responsible for the refraction fee of $60.00. This is in addition to the co-pay and will be collected at the time of service.

We do accept VSP and EyeMed vision plans. If you have one of these vision plans and want to use it, you must tell us when making the appointment. If you are seen and have not informed us of these plans until after the appointment, you will still be responsible for the refraction fee.

Signature: _____ Date: _____