

**CONFIDENTIAL PATIENT INFORMATION**

Name \_\_\_\_\_ (M/F) DOB \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Patient's Marital status \_\_\_\_\_

Occupation \_\_\_\_\_  M  D  S  W \_\_\_\_\_

E-mail \_\_\_\_\_ Preferred title: \_\_\_\_\_

Address \_\_\_\_\_  Mr  Mrs  Ms  Miss  Dr  Other \_\_\_\_\_

Patient's Social Family Physician \_\_\_\_\_

Security#: \_\_\_\_\_ Physician \_\_\_\_\_ Phone \_\_\_\_\_

Person or party Driver's Relation to \_\_\_\_\_

Responsible for payment: \_\_\_\_\_ License \_\_\_\_\_ Patient: \_\_\_\_\_

Referred by:  Web site  Family / Friend  Doctor \_\_\_\_\_

Location  Phone book  Insurance Whom may we thank? \_\_\_\_\_

Last eye Last eye \_\_\_\_\_

Examination date: \_\_\_\_\_ Doctor? \_\_\_\_\_

Special vision \_\_\_\_\_

Needs / Hobbies \_\_\_\_\_

List all medications you take including birth control pills and medicines you take without a prescription: \_\_\_\_\_

List anything you are allergic to, including medications: \_\_\_\_\_

Are you presently being treated for any medical condition? Any chronic conditions? Pregnant? \_\_\_\_\_

Do you use cigarettes / tobacco? Y / N Alcohol? Y / N Other? \_\_\_\_\_

Please indicate if you or a blood relative have any of the following:

- You  Relative Diabetes
- You  Relative Heart Disease
- You  Relative High blood pressure
- You  Relative Glaucoma
- You  Relative Macular degeneration
- You  Relative Retinal detachment
- You  Relative Arthritis
- You Respiratory problems (breathing)
- You Cancer / tumor
- You Eye injury / eye surgery
- You Other medical problem

Indicate the best answer for eye problems:

- Seldom  Occasional  Often Itchy eyes
- Seldom  Occasional  Often Red rims of eyes
- Seldom  Occasional  Often Gritty eyes
- Seldom  Occasional  Often Discharge from eyes
- Seldom  Occasional  Often Stinging eyes
- Seldom  Occasional  Often Dry eyes
- Seldom  Occasional  Often Teary eyes
- Seldom  Occasional  Often Light sensitive
- Seldom  Occasional  Often Lumps / bumps on lids
- Seldom  Occasional  Often Vision fluctuates when reading

*Richard R. Rigsby, O.D. & Carole L. Rigsby, O.D.*  
**Financial and Insurance Policy**

As a courtesy, we will file most insurance claims for you if we have the following information:

1. Photocopies of the front and back of your valid insurance I.D. card(s).
2. Authorization to file insurance claims and receive direct payment for services.
3. Notification of changes in your insurance coverage, address or phone number.

Patient Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**Primary insurance company** \_\_\_\_\_ Phone # \_\_\_\_\_

Name of policy holder \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy holder's DOB \_\_\_\_\_ Policy holder's SSN: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary insurance company** \_\_\_\_\_ Phone # \_\_\_\_\_

Name of policy holder \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy holder's DOB \_\_\_\_\_ Policy holder's SSN: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

**Vision Plan** \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy holder \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy holder's DOB \_\_\_\_\_ Policy holder's SSN: \_\_\_\_\_

Employer \_\_\_\_\_

- ✓ Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductible, co-pay, covered charges, and "usual and customary" charges.
- ✓ All charges are your responsibility whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- ✓ If your insurance company does not pay your claim within 30 days it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, it is your responsibility.
- ✓ If your insurance company does not pay within 45 days, we will require you to pay the balance. We accept cash, check, money order, Mastercard, Visa, American Express, Discover, and CareCredit.
- ✓ Payment for co-pay and or deductible is due at the time services are rendered.
- ✓ Returned checks and unpaid balances are subject to collection and placement fees.
- ✓ Refraction may not be covered by your insurance. You may be charged additionally for this service.

**ASSIGNMENT AND RELEASE: I authorize the physician to release any information required to process my insurance claim. I also authorize my insurance benefit to be paid directly to the physician, and I understand I am financially responsible for non-covered services as well as reasonable collection and billing fees.**

**PRIVACY PRACTICES: I acknowledge that I have received and/or read a copy of this office's "Notice of Privacy Practices."**

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_