

Confidential Patient Information

Name: _____ (M / F) DOB: _____ Date: _____

Address: _____ City/State/Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Patient's Occupation _____ Marital Status _____
 M D S W

E-mail Address: _____ Preferred title: _____
 Mr. Mrs. Ms. Miss Dr. Other

Patient's Social Security #: _____ Family Physician Phone _____

Person or party Responsible for payment: _____ Driver's License # _____ Relation to Patient _____

Referred by: Website Family / Friend Doctor Location Phone book
Whom may we thank? _____

Last eye Examination date: _____ Last eye Doctor? _____

Special vision _____

Needs / Hobbies _____

List all medications you take including birth control and all medications 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 Kidney disease
- 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: _____