725 E. Main St. Suite 1C
Somerton, Arizona 85350
PH: (928) 627-4525
Fax: (928) 627-4524

PATIENT INFORMATION DATE: ________________

First Name____________________ Last Name__________________ Middle ________________
Birth date _____________ Sex: ( ) Male ( ) Female Social Security No. __________________
Mailing Address_________________________________P.O. Box_________________________
City ___________________________________ State _______________ Zip ________________
Phone: (Home) _________________ (Cell)____________________
EMAIL:________________________

OCULAR HISTORY
Date of last exam ____________________ Name of Doctor _____________________________
Do you wear glasses ( ) Yes ( ) No If yes, ( ) all the time ( ) occasionally ( ) reading ( ) driving
Do you wear contacts ( ) Yes ( ) No / ( ) Soft ( ) Hard, Brand:____________________________
Whom may we thank for referring you to this office? ___________________________________
Please list any **medication** you are taking____
____
Please list any **eye drops**____
Please list any medications you are **allergic** to ____
Are you pregnant or nursing? ( ) Yes ( ) No
Do you smoke? ( ) Yes ( ) No
Do you drink? ( ) Yes ( ) No

Do you have or have you had any of the following within the past year? (Check any that apply)

___ Eye injury
___ Eye Surgery
___ Eye infections
___ Sticky discharge
___ Itchy eyes
___ Burning eyes
___ Double vision
___ Watery eyes
___ Red eyes
___ Pain in eye
___ Frequent headaches
___ Blurry vision
___ Glaucoma
___ Diabetes
___ Cataracts
___ Floaters
___ High blood pressure

INSURANCE INFORMATION (MEMBER)
Primary insurance:
Name of Insured _______________________________ Insured's Date of Birth_______________
Insured's Social Security # _____________________ Policy/ ID # _________________________
Insured's Employer _______________________ Insured's Employer Phone # _______________
Insurance Company __________________________

Secondary/ Supplemental insurance:
Name of Insured_______________________________ Insured's Date of Birth_______________
Insured's Social Security # ______________________ Policy/ ID # _________________________
Insured's Employer _______________________ Insured's Employer Phone # _______________
Insurance Company __________________________

Cancellation Policy: We require 24 hour advance notice of cancellation. If you are unable to make your appointment, please call the office so other patients who are in need of treatment can be scheduled accordingly.

Missed Appointments: Patients who do not show up for their scheduled appointment without a 24 hour advanced notification will be considered missed/failed appointments and will have a charge of $30.00.

Tardiness: Patients who are more than 15 minutes late for their treatment appointment may not be seen and may be rescheduled, unless you have called our office and let us know about your delay then you can be seen depending if office has a no show appointment.

Appointments for Treatment: Please be advised that only one parent/guardian will be allowed in the treatment room due to limited space. Please make arrangements for your other children, as they will not be allowed in the treatment room unless they are being seen.

Family Member Appointments: Only three (3) members of a family may be scheduled on the same day for treatment. We apologize for any inconvenience this may cause.

Cell Phone usage in the office and in exam/treatment rooms: Please be advised that the use of your personal cell phone in the exam and treatment rooms is strictly prohibited. Recording or taking pictures during visit with any type of device is also prohibited.

Authorization to Release Information:

Name:___________________________ DOB____________________Relationship__________________
Name:___________________________DOB_____________________Relationship__________________

Insurance Agreement and Release:
I, the undersigned, certify that I or my dependent have insurance coverage with the above Insurance Company and assign directly to Somerton Eyecare Center, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please check method of today's payment ( ) cash ( ) check ( ) debit/credit or ( ) Care Credit.

Financial Policy:
In the event that I/we have failed to pay for services provided by this office, and the account is placed for collection, I/we understand and agree that an additional amount equal to 40 % of the balance owed at the time the account is placed for collection, will be added to the current balance owed, I/we agree to pay interest at the rate (10%) ten percent per annum until the amount owed is paid in full. I/we further agree to pay all attorneys fee and court cost, necessary to collect this balance.
Non sufficient checks will be charged an additional $25 fee.

I agree to pay any collection fees and all other costs that may incur to enforce collection of any amount outstanding.

I acknowledge that I have read, understand, and am willing to comply with the above guidelines and finance responsibility.

Date_____________________Signature____
Print patient/responsible name____

THANK YOU for trusting us here at Somerton Eyecare Center, Inc. with your vision needs.