SOMERTON EYECARE CENTER
OPTOMETRIST: Dr. Jesse V. Dominguez

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

PATIENT INFORMATION eff. 01/01/2023 DATE: _____

First Name_____ Last Name_____ Middle _____
Birth date _____ Sex: ( ) Male ( ) Female Social Security No. _____
Mailing Address_____P.O. Box_____
City _____ State _____ Zip _____
Home Phone:_____ 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 Alcohol? ( ) Yes ( ) No
Additional Comments: Is there anything else we should know about?
_____
_____

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

___ Eye injury R/ L	___ Double vision R/L	___ Glaucoma
___ Eye Surgery R/ L	___ Watery eyes R/L	___ Diabetes
___ Eye infections R/L	___ Red eyes R/L	___ Cataracts R/L
___ Sticky discharge R/L	___ Pain in eye R/L	___ Floaters R/L
___ Itchy eyes R/L	___ Frequent headaches	___High blood press.
___ Burning eyes R/L	___ Blurry vision R/L	

INSURANCE INFORMATION (MEMBER)
Primary insurance:

Name of Insured _____ Insured's Date of Birth_____
Insured's Social Security # _____ Policy/ ID # _____
Insured's Employer _____ Insurance Company _____

Secondary/ Supplemental insurance:
Name of Insured_____ Insured's Date of Birth_____
Insured's Social Security # _____ Policy/ ID # _____
Insured's Employer _____ 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. This is not covered by your insurance. After 3 missed appointments, may result in dismissal from our practice.

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:

On April 14, 2003 a new Federal Law, HIPAA, went into effect to protect your personal health information (PHI) If you need to authorize someone else to have access to your records in our office please list them and their relationship to you below. Please note, that under this new law we cannot release information to a spouse or a parent if the minor is 18 or older, regardless of who is responsible for the charges.

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.

Responsible Party Signature: _____ Date: _____

Insurance Policy:
Insurance co-payments and/ or deductible amounts are due at the time services are rendered.

Any balances not paid by the insurance company will be billed to the patient. Payment is expected upon receipt of statement.

We will gladly bill your insurance on your behalf, however we cannot guarantee payment of your claim. If we are unable to collect payment from your insurance company or they deny your coverage you will be responsible for the balance.

Fees

Comprehensive Vision Examination:	$144- $169 ($99 cash discount)
Contact Lens Examination, Starting at	$149- $189 (excluding specialty contacts)
-Medical office visit for eye injury - minimum	$54 average $87
-Medical Fundus photography	$92.68 ($55 cash discount)
-OCT, scanning computerized ophth imaging	$55.04 ($44 cash discount)
-Refraction only	$30

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 $35 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.

Patient Name: _____ Date: _____

Responsible Party/ Guardian Signature: _____

Print Name: _____ Relationship: _____ Date of Birth:_____

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