Welcome to Eyetopia

We are happy to have you as our patient.
In order to provide the best possible care for you, please provide the information below.

Last Name	First Name	Date
Home Address		
City	State	Zip Code
Home Phone	Work Phone	Mobile Phone
Email		
Date of Birth	Social Security Number	
Place of Employment	Position	
Physician	Last Exam Date	Phone
Person Responsible for Payment of Account		
Name of Primary Insured		Place of Employment
Medical Insurance	Vision Insurance	
SSN # or ID # of Insured		Date of Birth of Insured
Whom may we thank for referring you to Eyetopia Eyecare?		

THIS OFFICE DOES NOT BILL FOR PROFESSIONAL SERVICES OR LABORATORY FEES

I will be paying today by CASH____________CHECK___________CREDIT CARD___________

I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED OR PRODUCT(S) PROVIDED. I HAVE READ ALL OF THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES OF THE ABOVE INFORMATION.

- I authorize the release of any information including diagnosis and records of any treatment or examination rendered to me or my dependent during the period of such care to third party payers and /or other healthcare practitioners.
- Should any of the services provided today not be covered, or considered not medically necessary by Medicare or my insurance company, I will be financially responsible for payment of all charges incurred for services received from this doctor's office.
- I authorize and request my insurance company to pay directly to:
  Dierdre Fogle, O.D., dba Eyetopia Eyecare
- I acknowledge that I have access to a copy of Eyetopia Eyecare's Notice of Privacy Practices.
- I acknowledge that there are no refunds.

______________________________ ______________________________
PATIENT SIGNATURE (or Guardian if a Child) DATE