BURLINGTON EYE CARE

WELCOME TO OUR OFFICE!!

Please take a few moments of your time to complete the following demographic sheet. Please answer all questions to the best of your ability. It will help us to better serve you.

TODAY'S DATE:______________ EMAIL ADDRESS: ______________________________

PATIENT'S NAME:____
(Last) (First) (MI) (Maiden)

ADDRESS:____
(Street) (City) (State) (Zip)

Title (Circle): Mr. Mrs. Miss Ms. Dr. Rev. Gender: Male Female

Date of Birth:______________ Age:__________ Race:__________ SSN:______________

Primary Phone #:______________________ Message Phone #:______________________

TEXTING OK? Y/N (CIRCLE ONE) EMAILING OK? Y/N (CIRCLE ONE)

Are You Employed: Y / N Place of Employment:______________________ Year Retired__________

Occupation:______________________ Work Phone#:______________________

Marital Status: Single Married Divorced Widowed Other______________________

If Married, Name of Spouse:______________________ Date of Birth______________ SSN:__________

Place of Spouse Employment:______________________ Phone #:______________ Occupation:__________

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If Patient is Child: **Father:** ______________________ Work Phone #:______________________

SSN:______________________ Date of Birth:______________________

Place of Employment:____

Mother: ______________________ Work Phone #:______________________

SSN:______________________ Date of Birth:______________________

Place of Employment:____

Guardian: ______________________ Work Phone #:______________________

SSN:______________________ Date of Birth:______________________

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Do You Have Any Vision Insurance: Y / N If so, What?______________________________

Do You Have Any Health Insurance? Y/ N If so, What?______________________________

PLEASE SHOW YOUR INSURANCE CARDS TO THE RECEPTIONIST SO SHE MAY MAKE COPIES OF THEM.

Office Payment Policy: All exam fees are due and payable at the time the services are rendered. A non-refundable deposit of one-half the total fee is required before glasses can be ordered. The balance is due when the materials are dispensed to the patient. However, if the materials are not picked up within 30 days the remaining balance is still due. If your fees are covered under an insurance program, we will be pleased to complete your insurance form for you. Contacts have to be paid in full before ordering. I authorize all insurance companies to pay Burlington Eye Care directly on my behalf.

In consideration of the services provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the arrangements made at the time of service or, if no such arrangements are made, in event of default in payment , reasonable collection agency fees equal to twenty (25%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

I further authorize the release of and medical information necessary to process any insurance claims for vision or medical care rendered to me by Dr. Horn, Dr. Matthews, and / or their staff. These authorizations remain in effect until withdrawn by me.

Signature of Patient (Guardian)______________________________ Date:______________