Welcome to Natural Eyes of Weston

Patient Information

Thank you for choosing our office for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. ***Please print.***

Name _____ Date _____
First Middle Initial Last

If Child, Parent's Name _____ Spouse _____

Address _____ Apt _____ City _____ State _____ Zip _____

Birth date _____ Age _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email address _____

Occupation _____ Employer _____

Person to Contact in case of emergency _____ Phone _____

How did you hear about our office? _____

Responsible Party

Payment is due when services are rendered. We accept cash, local checks, American Express, Visa, MasterCard, and Discover. Please present Photo ID when paying by check or credit card.

Name of person responsible for this account? _____

Relationship to Patient _____ DL # _____

Insurance Information

Please present your insurance card(s) so that we can make a photocopy for our records.

Name of Insured _____ Relationship to Patient _____

Address of Insured _____

Date of Birth _____ Last 4 of Social Security # _____

Name of Employer _____ Work Phone # _____

Plan _____ Group _____

Additional Insurance Plan _____ Group _____

Authorization

I authorize Natural Eyes of Weston, LLC (provider) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the provider insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

I acknowledge that I have reviewed the Notice of Privacy Practices.

X _____ *Date* _____

Please list any family members/friends who you would like to authorize release of your medical records to below:

_____

_____