WHITSETT VISION GROUP

PATIENT DEMOGRAPHIC AND INFORMATION

Last Name: **First Name:** **MI:**		**Other Names Used:**		
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____	**Marital Status:** ☐Single ☐Married ☐Divorced ☐Separated ☐Widow	**Birth date:** / /	**Age:**	**Sex:** ☐ Male ☐ Female
Street Address/ Apt/Suite:		**City:**	**State:**	**Zip code:**
Email Address:				
Cell Phone #:		**Alternate Phone #:**		
Emergency Contact Name/Relationship to Patient:		**Emergency Contact Phone #:**		

Race (Select one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other (specify):_____ ☐ Declined to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Were you referred by a doctor/optometrist? ☐ Yes ☐ No *If ***Yes*****,** please let us know who referred you. → → → → → → →	**Referring Physician Name:**		
How did you hear about us? (please check one box) Provide additional detail as needed.	☐ Friend/Family	☐ Internet Search	☐ Insurance Plan
	☐ Radio	☐ Social Media	☐ Doctor/Optometrist

PERMISSION TO RELEASE INFORMATION

Please list the names of people we may contact and share information with regarding your health and private information. This does not need to include other healthcare providers or insurance companies, as they are included in your circle of care. An example would be **your spouse, children, relative or close friend.**

Name:	**Phone #:**
Name:	**Phone #:**
Name:	**Phone #:**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices from the office of Whitsett Vision Group.

ACKNOWLEDGEMENT OF INSURANCE & FINANCIAL RESPONSIBILITY

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I understand any referral that is required by my insurance I will fully be responsibly to obtain, not the office. I also authorize WHITSETT VISION GROUP or insurance company to release any information required to process my claims.

PATIENT/Legal Guardian Signature:	**Date:**

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MEDICAL HISTORY INFORMATION

Patient Name:	Date of Birth:	Today's Date:
Patient Home Address:		Patient Primary Phone Number:
Family Physician Full Name & Phone #:		Referring Doctor Full Name & Phone #:
Pharmacy Name and Phone Number:		Email Address:

Medical History (including chronic illnesses, eye disease, eye trauma):

Medication Allergies:

Current Medications (including eye drops)

Medication Name:	Dosage:	Purpose:

Surgical History (including eye surgeries)

Surgery Name:	Year:

Family History (please indicate which family member)

	Mother	Father	Brother	Sister	Daughter	Son	Other
Diabetes							
High Blood Pressure							
Heart Disease							
Lung Disease							
Glaucoma							
Retinal Disease							
Macular Degeneration							
Cataracts							

Social History

Do you drink alcohol?	☐ **YES**	☐ **NO**	**If yes, how much per day?**
Do you smoke?	☐ **YES**	☐ **NO**	**If yes, which type?** **Packs per day?**
If yes, have you ever quit smoking?	☐ **YES**	☐ **NO**	**If yes, when?**

WHITSETT VISION GROUP

PATIENT FINANCIAL RESPONSIBILITY

Whitsett Vision Group (WVG) is dedicated to providing courteous, efficient, and high-quality care. Patient satisfaction is our top priority. As a courtesy, we file insurance claims on behalf of our patients and make every effort to ensure they are processed promptly and accurately.

The purpose of this form is to assist our patients in understanding their medical insurance coverage in relationship to our office policies.

- Patients are responsible for knowing and understanding their own insurance policy, eligibility, and coverage.
- We render our services on the basis that insurance companies may or may not pay for all but a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for services rendered.
- Not all insurance companies/third party payors pay for all services; each policy has its own stipulations regarding covered services or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are responsible for payment of outstanding deductibles and co-insurance amounts at time of service. Co-payments will be collected at the time of service.
- If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit.

  FAILURE TO OBTAIN THE REFERRAL AND/OR PREAUTHORIZATION WILL RESULT IN A LOWER OR NON-PAYMENT FROM YOUR INSURANCE COMPANY. THE BALANCE WILL BE YOUR RESPONSIBILITY AT THE TIME SERVICES ARE RENDERED.
- Patients are financially responsible for payments of all non-authorized procedures, office visits lacking a proper insurance referral, and non-covered services.
- Returned checks are subject to a $35.00 service charge to your account, along with the insufficient funds amount.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-insurance, and any amount exceeding what my insurance company pays except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, pre-authorizations, and second opinions.

I HAVE READ THE ABOVE WAIVER, AUTHORIZATION AND ACKNOWLEDGEMENT, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Patient/Legal Guardian Name (PRINT):	**Patient Date of Birth:**
Patient/Legal Guardian Signature:	**Date:**
Witness Signature:	**Date:**