KEELY HOBAN, OD • DAVID CARKNER, OD • EMILY BEE, OD

Patient Information Form

First Name ______________ Last Name ______________ Preferred Name ______________

Street Address ______________ City ______________ State ______________ Zip ______________

Last 4 of SSN ______ Date of Birth ______ Email address ______________ Cell Phone ______________

Gender Identity ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer / Non-conforming ☐ Additional Identity, please specify: ______________________ ☐ Decline to answer

Preferred Pronouns: ______________

Primary Medical Insurance Information

Primary Insurance Company ______________ Group # ______________ Member ID / Policy # ______________

Subscriber's First Name and Last Name ______________ Subscriber's DOB ______________ Subscriber's Last 4 of SSN ______________

Patient Relationship to Subscriber Marital Status ☐ Single ☐ Married ☐ Other ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Medical Insurance Information

Name and Address of Secondary Insurance Company ______________ City ______________ State ______________ Zip ______________

Vision Insurance Information

☐ EyeMed ☐ VSP ☐ Other ______________________________________

New Patients Only:

Who can we thank for referring you to our office? _____________________

If not referred, how did you choose our office?_______________________

Please read:

I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a service charge on all returned checks. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Peak Vision Clinic. I understand that billing any out of network or secondary insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Patient Signature: ____ **Date** ______________

Guardian Signature (if applicable): ____________________________________ **Date** ______________