**WELCOME TO SYRACUSE FAMILY EYECARE**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_

**Patient First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Primary insured:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_ **Relationship to patient**:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For our new patients:**

**Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information-**

**Please present your insurance cards (both medical and vision).**

***Most Medical insurances do not cover routine vision care and eyeglasses.***

**If you have any questions about your coverage, please call the number(s) listed on the back of your insurance card and make inquiries regarding your routine vision coverage.**

Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Who will be responsible for payment on the account for today?)

**\*\*\* PLEASE SIGN FORM WHERE INDICTATED\*\*\***

\_\_\_ I **assume responsibility for payment of my account at the time of service.**

**\_\_\_\_ I authorize Syracuse Family Eyecare to release any medical information necessary in order to process my insurance claim and authorize payment of benefits to Syracuse Family Eyecare.**

**­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

**MEDICARE PATIENTS ONLY**

**I authorize the release of any medical information necessary to process my claims. I request payment of government benefits either to myself or to the party who accepts assignments. I also authorize payment of all other medical benefits filed by Syracuse Family Eyecare to Syracuse Family Eyecare.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

**1. Is this patient a Veteran?** \_\_\_ Yes \_\_\_ No

If YES, does the patient authorize Syracuse Family Eyecare to bill the Veteran’s Administration? \_\_\_ Yes \_\_\_ No

**2. Is this medical condition due to an accident of any kind?** \_\_\_ Yes \_\_\_ No

If YES, Was it work related? \_\_\_ Yes \_\_\_ No Auto Accident? \_\_\_ Yes \_\_\_ No

Injured at Home? \_\_\_ Yes \_\_\_ No

**3. Is this medical condition covered by another health plan through the patient’s employer or spouse employer?** \_\_\_ Yes \_\_\_ No

**INSURANCE AND MEDICAID PATIENTS**

**I assume responsibility of my account in the event that Medicaid *or* any other insurance denies my claim.**

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Signature Date

**\_\_\_ I have received Syracuse Family Eyecare’s Notice of Privacy Practices.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Patient/Parent/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient Witness

\_\_ Attempted to distribute the Notice of Privacy Practices to the patient/parent, legal guardian but the patient, parent, legal

guardian declined to acknowledge the receipt of the Notice of Privacy Practices.

\_\_ Patient stated had already received the Privacy Notice.

\_\_ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian.

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Witness Date

**QUESTIONAIRE**

Are you interested in the newest digital technology to enhance your vision? Y\_\_\_ N\_\_\_

Do you use a computer frequently? Y\_\_\_ N\_\_\_

Are there times when you don’t want to wear glasses? Y\_\_\_ N\_\_\_

Do you have children at home? Y\_\_\_ N\_\_\_

Do you spend a lot of time outdoors or suffer from sunlight sensitivity? Y\_\_\_ N\_\_\_