PATIENT INFORMATION SHEET

Office of David E. Scott, O.D.

Patient Acct. # _____

Legal Name: (First) _____ (Last) _____ (Middle Initial) _____

Nick Name: _____Gender: _____M _____F Date of Birth: _____

Address: (Street) _____(City) _____(State) _____(Zip) _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

E-Mail: _____I Prefer to be contacted at __ HM __ WK__ Cell__ Email

(CHECK ONE)

Social Security #: _____ Spouse's Name: _____Phone: _____

Marital Status: _____ Language: _____Race: _____

Ethnicity: **(CHECK ONE)**

Not Hispanic or Latino ____Hispanic or Latino ____ Unknown ____ Patient declined to answer ____

Occupation: _____ Place of Employment: _____

Employment Address: _____

Emergency Contact Person: _____ ____Phone #: _____

Release of Medical Information Authority: _____Phone: _____

Primary Medical Doctor's Name: _____Address: _____

Doctor's Phone: _____Referred By: _____

RESPONSIBLE PERSON FOR PAYMENT: (If same as above, write the word 'Same')

Name: (Last) _____(First) _____ (Initial) ____ (Relationship) _____

Address: (Street) _____

(City) _____ (State) _____ (Zip) _____

Date of Birth: ___/___/_____ Place of Employment: _____

PAYMENT POLICY: All fees are due at the time of services and/or materials are provided. If Dr. Scott is a provider for your insurance, we will file your insurance. Any balance remaining after the insurance is finalized; the payment for remaining balance is due at that time.

INSURANCE INFORMATION: We participate with many insurance plans. If your insurance coverage is with a company with which we do not participate, we will supply you with the necessary information to file your insurance. Any reimbursement you receive from your insurance company depends upon the terms of your contract, not on the fees for services and materials provided by our office. After insurance claims are finalized any remaining balance becomes the responsibility of the patient or the person responsible for the account.

Please complete all that apply:

Primary Medical Insurance: _____Birth Date of Contract Holder: ___/___/_____

Name of Contract Holder: _____

Address: (Street) _____(City) _____(State) _____(Zip) _____

Secondary Medical Insurance: _____Birth Date of Contract Holder: ___/___/_____

Name of Contract Holder: _____

Address: (Street) _____(City) _____(State) _____(Zip) _____

Primary Vision Insurance: _____Birth Date of Contract Holder: ___/___/_____

Name of Contract Holder: _____ _____Last four digits of SS#: _____

Address: (Street) _____(City) _____(State) _____(Zip) _____

Secondary Vision Insurance: _____Birth Date of Contract Holder: ___/___/_____

Name of Contract Holder: _____ _____Last four digits of SS#: _____

Address: (Street) _____(City) _____(State) _____(Zip) _____

I authorize the release of any medical or other information necessary to process my insurance claims. I understand that any balance after my insurance has paid is my responsibility.

_____: _____
(Date) (Patient's or Responsible Person's Signature)

Please have your Vision and Medical Insurance Cards available for the receptionist to scan.