## PATIENT INFORMATION

Last Name:_____First Name:_____MI:_____
Address:_____City:_____State:_____Zip:_____
DOB:_____SS#_____

Name of person responsible for this account:_____
Relationship to patient:_____Phone:_____

IF YOU WISH US TO BILL AN INSURANCE COMPANY FOR YOU, THE FOLLOWING INFORMATION IS REQUIRED (Failure to supply the required information, will result in patient being billed for the visit in full at time of service)

## MEDICAL INSURANCE

Medical Insurance:_____Primary's Full Name:_____
Primary's SS#_____
Primary's Employer:_____Primary's Occupation:_____
Relationship to primary: SELF SPOUSE/DOMESTIC PARTNER CHILD other:_____

## VISION INSURANCE

Vision Insurance:_____Primary's Full Name:_____
Primary's SS#_____Primary's DOB:_____
Primary's Employer:_____Primary's Occupation:_____
Relationship to primary: SELF SPOUSE/DOMESTIC PARTNER CHILD other:_____

- Payment is due when services are provided. We accept cash, Visa, Discover and Mastercard, please ask for details.
- You are responsible at time of visit for any: CO-PAYMENT, CONTACT LENS FITTING FEE, VISUAL FIELD EXAM FEE AND FEES FOR EYEGLASSES; all fees will be discussed with you prior to you receiving services

I authorize Jamesburg Family Eyecare and Dr. Magdalena Spiewak to perform all necessary tests to insure proper diagnosis and treatment of any eye condition. I also authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I realize that insurance information and benefits must be presented and verified at the time of the service. We cannot refund you for insurance benefits that were not verified or available at the time of the service date.

_____ _____
Signature of Patient/Parent/Guardian Date