

Hoover Vision Center, P.C.

PATIENT INFORMATION

(Please Print)

Date: ___/___/___ New _____ Update _____

Last name _____ First name _____ Middle _____

Preferred name _____ Date of Birth ___/___/___ Age _____ Sex: *M/F*

Social Security ___ - ___ - _____ Drivers License # _____ Marital Status: *S/M/W/D*

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Other Phone _____ Email _____

Preferred Contact: *Home Phone / Cell Phone / Work Phone / Email / Regular Mail*

Preferred Language: *English / Spanish / _____* Ethnicity: *Hispanic/Latino // Not Hispanic/Latino*

Race: *American Indian or Alaskan Native / Asian / Black or African American*

Native Hawaiian or Pacific islander / White

Occupation _____ Status: *Employed / Retired / Unemployed / Disabled*

Employer _____ If Student: Grade _____ School _____

Who referred you to this office? _____

Please list any family members who are patients of this office.

Name	Relation	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information

Primary (*medical*) _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Secondary (*medical*) _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Vision Plan _____ Policy # _____

Insured Name: _____ Insured DOB _____

****Please have insurance cards and drivers license available for receptionist to copy****

Please turn this form over and complete side two

Financial Information

Is patient responsible for bill? Yes / No If not, complete the following information:

Guarantor: Last name _____ First name _____
 DOB ____/____/____ Social Security # _____
 Address _____
 Home phone _____ Work Phone _____
 Employer _____ Relationship _____

Note: Minors must be accompanied by an adult for examination and when picking up materials.

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your co-pay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. *If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information.* If you have any questions about your insurance or account, please feel free to contact our insurance and billing coordinator.

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Hoover Vision Center, P. C. for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney’s fee, should the account be referred to an attorney for collection. I further agree to waive my rights of exemption as to personal property.

I understand that a finance charge of 1.5% per month shall be added to all balances over 30 days.

I have read the above policies and agree as indicated by my signature.

Patient or Responsible Party Signature

Date