

# WELCOME TO ESTRELLA EYECARE

Please fill out completely. *If there is nothing to list, write "N/A" (non applicable).* Today's Date: \_\_\_/\_\_\_/\_\_\_

**Patient Information:**

( Mr/Mrs/Miss/Ms/Dr ) Patient Name: \_\_\_\_\_  
Last, First MI

Social Security# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Home

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell

Email: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Work

(EMAIL is used to communicate with you for appointment confirmations, updates, etc)

**NOTE: All Patient information is kept strictly confidential. Your information is NEVER shared**

Marital Status: Single  / Married  / Widowed  / Other  Spouse's name: \_\_\_\_\_

**Patient / Parent Employment Information:**

If child, name of parent: \_\_\_\_\_ Parent's DOB: \_\_\_/\_\_\_/\_\_\_

Employment Status: Full-Time \_\_\_ Part-Time \_\_\_ Student/Child \_\_\_ Retired \_\_\_ Not Employed \_\_\_

Employer: \_\_\_\_\_ Occupation/Job: \_\_\_\_\_

## Receipt of Notice of Policy Practices & Consent Form

Effective date of notice: April 1, 2003

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form.

**Please list any of those responsible individuals that you will allow personal information, glasses, or contact lenses to be released to by our office. Proper identification will be documented whenever information is released to any of the people listed below. Examples of those individuals might be: spouse, the other parent, older sibling(s), grandparent(s), stepparent, aunt/uncle, or other caregiver. Only the minimum necessary information will be provided.**

Date	Names of those individuals allowed to receive personal patient information incl. glasses and contact lenses	Relationship to patient	Date of Birth	Any restrictions?

**I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from ESTRELLA EYECARE, and I allow those listed above to receive limited personal patient information in my absence.**

Signature of Patient / Parent / Guardian

Date

***Please turn this form over and complete side two***

# WELCOME TO ESTRELLA EYECARE

Please fill out completely. *If there is nothing to list, write "N/A" (non applicable).* Today's Date: \_\_\_/\_\_\_/\_\_\_

## **Vision Insurance:** (Check all that apply):

VSP \_\_\_ VCP \_\_\_ BCBS \_\_\_ EYEMED \_\_\_ TRICARE \_\_\_ HEALTHNET \_\_\_ VCD \_\_\_ MEDICARE \_\_\_ CIGNA \_\_\_  
WORKERS COMP \_\_\_ NONE \_\_\_ OTHER \_\_\_\_\_

Primary member: \_\_\_\_\_ Patient's relationship to primary: Self / Spouse / Child / Other

Member ID #: \_\_\_\_\_ (circle one)

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

***We will need a copy of your vision insurance card to copy for the records if applicable.***

## **Medical Insurance (Primary) :**

Name of Medical Insurance: \_\_\_\_\_

Primary member name: \_\_\_\_\_

Patient's relationship to primary: Self / Spouse / Child / Other

Member ID/Social Security #: \_\_\_\_\_

Primary member's employer: \_\_\_\_\_

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

Office Use

Only Effective Date \_\_\_/\_\_\_/\_\_\_

Copay \$ \_\_\_\_\_

Exam:

Materials:

## **Medical Insurance (Secondary) :**

Name of Medical Insurance: \_\_\_\_\_

Primary member name: \_\_\_\_\_

Patient's relationship to primary: Self / Spouse / Child / Other

Member ID/Social Security #: \_\_\_\_\_

Primary member's employer: \_\_\_\_\_

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

Office Use

Only Effective Date \_\_\_/\_\_\_/\_\_\_

Copay \$ \_\_\_\_\_

Exam:

Materials:

***We will need a copy of your medical insurance card to copy for the records.***

**Patient Consent:** The above questions were answered to the best of my knowledge. I authorize the release of information pertaining to this vision examination to my insurance carrier(s), my physician(s), concerned eye care professionals, or in the case of a child, educational specialists (teachers, school nurse, etc.) under the following conditions: 1) detailed description of the information being released, 2) to whom may the information be released, 3) the purpose for the release, 4) expiration date or event. In the case of a minor, I (the parent/legal guardian) authorize Estrella EyeCare to treat my child for any eye-related care, if I am not present. I agree to pay for any and all services/products at the time of this eye exam if I do not have insurance or if it is not valid per prior authorization, or if insurance is valid I will pay the difference the insurance pays.

We do not accept insurance assignments other than those above. If your insurance is not listed please ask the receptionist if we are a provider.

**Payment is required at the time of services rendered.**

Patient (or parent/legal guardian): (signature) \_\_\_\_\_ Date: \_\_\_\_\_