Alameda Vision Center

Responsible Party Information:

Patient Name: _____ **Date of Birth:** _____ **Sex: M F**
(First) (M.I.) (Last)

Parent or Guardian: _____ **SSN:** _____
(First) (M.I.) (Last)

Home Address: _____

City:_____ **State:** _____ **Zip:** _____

Phone (H): _____ **(C):** _____ **(W):** _____

Employer: _____ **Occupation:** _____

Emergency Contact Name: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Email: _____

Pharmacy: _____ **Phone #:** _____

Insurance Information:

Primary Insurance: _____ **Policy #:** _____

Policy Holder's Date of Birth: _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's SSN:** _____

Secondary Insurance: _____ **Policy #:** _____

Policy Holder's Date of Birth: _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's SSN:** _____

Optomap will likely be an important part of your eye exam today. It is a quick and efficient way of monitoring your eye health for early signs of disease before you notice any symptoms. Many patients will be **able to bypass routine dilation** by doing this. This Optomap is a digital photo of your retina (back of eye) that the doctors keep to compare and track changes in the future. More information is available by request. The **cost of this service is $15.00** and **not covered by insurance.** If you wish to have this service performed as part of your exam please check **YES** [ ] or **NO** [ ]

****Note:** Some patients will still need dilation and/or extra medical testing; your eye doctor will discuss this with you

Contact Lens Evaluation:

Contact lens evaluation and prescription are an **additional service** and are not part of a routine healthy eye exam. Most vision insurance companies **do not cover** the associated fee of this additional testing.

Payment Policy

Payment is due at time of service. A 50% deposit is required **before** materials are ordered. The balance is due in full at time of delivery. Third party payment (insurance) will be filed on your behalf; however payment must be received before dispensing. Any insurance benefit in excess of the account balance will be immediately refunded to the patient after we receive payment from the insurance company.

To my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes to my medical status.

Patient/Guardian Signature: _____ **Date:** _____