Chester Eye Center
Welcome To Our Office

Welcome to Chester Eye Center. Thank you for choosing us to provide your eye health and vision care. We appreciate the confidence you have placed in us. Please complete the following form, reviewing all information to ensure it is current and accurate. If you have any questions, do not hesitate to ask us.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State Zip ____

Social Security Number ____ Date of Birth ____ Home Phone - Include Area Code ____ Cell/ Day Phone ____

Guardian ____ Emergency Contact ____ Emergency Phone ____

Employer ____ Employer Phone ____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor ☐ Web Page

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ____ City ____ State Zip ____

M ☐ F ☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ____ City ____ State Zip ____

M ☐ F ☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

I understand that **my co-pay(s), deductible (s), and any patient balance** are to be paid in full at the time services are rendered. Professional services and material fees are charged to the patient. Any medical testing, which is not considered part of a routine eye exam, will be submitted to my medical insurance. As the undersigned, I will ultimately be responsible for **any bill incurred in this office for one year following this date regardless of insurance**. Overdue accounts will be subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance(s) is to be paid directly to Chester Eye Center. I understand that my primary/secondary insurance(s) will be billed and **any unpaid claims are my responsibility**. I further understand that all benefits quoted to me are **not a guarantee of payment** by my insurance company and that the final determination can only be made when the claim is processed. I understand my rights regarding my medical records. A copy of the Notice of Privacy Practices was made available to me.

Signature ____ Date ____