WELCOME TO OUR OFFICE

Full Name_____ Preferred Name_____
First M.I. Last

Street_____ City_____ State___ Zip_____

Phone Numbers – Preferred number (**CIRCLE ONE**: Home Cell Work)

Home (___) _____ Work (____) _____ Cell (____) _____

Email address_____ SS# _____

(We often use email to let you know of upcoming appointments, orders ready for pick-up, and a bi-monthly informational newsletter)

Birth Date_____ Age_____ Gender M F Marital Status: M S D W

Employer_____ Occupation_____

Spouse or Parent Information (circle one)

Name_____ Birth Date_____

Employer_____ Work#_____ Cell#_____

VERY IMPORTANT! ALL NEW PATIENTS

Who may we thank for referring you to our office?_____

If not referred, how did you choose our office for your needs?

- ❑ Saw Sign/Bldg
- ❑ Insurance List
- ❑ Our Website
- ❑ Another Dr._____
- ❑ Yellow Pages: Which Directory?_____
- ❑ Facebook: _____
- ❑ Yelp or Google_____
- ❑ Other:_____

Vision Insurance Information

Primary Insurance_____

Subscriber Name_____

Subscriber ID#_____

Subscriber Birth Date_____

Secondary Insurance_____

Subscriber Name_____

Subscriber ID#_____

Subscriber Birth Date_____

Medical Insurance Information

Primary Insurance_____

Subscriber Name_____

Subscriber ID#_____

Subscriber Birth Date_____

Secondary Insurance_____

Subscriber Name_____

Subscriber ID#_____

Subscriber Birth Date_____

Our office is happy to help you with your insurance benefits and provide the service of submitting the claim on your behalf. Please note that most insurance plans pay only a portion of the charges. We do not guarantee the accuracy of the benefit information given to us by your insurance company. All insurance amounts are estimated to the best of our ability and no amount is exact until we receive payment on a claim. The patient is responsible for any insurance non-payment or any amount less than anticipated by your insurance company.

I have read the above and agree to accept responsibility for any amounts not covered by my insurance. I also give this office permission to bill my insurance on my behalf. My signature below serves as "Signature on File" for claim processing.

Signature_____ Date_____

Updated_____ Initial_____

Updated_____ Initial_____

Updated_____ Initial_____

Updated_____ Initial_____

RIEMER EYECARE
Randall J Riemer, OD