

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?

- | | | |
|---|--|---|
| <input type="checkbox"/> Saw Sign/Bldg | <input type="checkbox"/> Insurance List | <input type="checkbox"/> Facebook: _____ |
| <input type="checkbox"/> Our Website | <input type="checkbox"/> Another Dr. _____ | <input type="checkbox"/> Yelp or Google _____ |
| <input type="checkbox"/> Yellow Pages: Which Directory? _____ | | <input type="checkbox"/> 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