



Swift Creek Eye Center, P.C., Optometrists

WELCOME

Thank you for choosing our office for your eyecare needs

PERSONAL INFORMATION

DATE

LAST NAME: _____ BIRTHDATE : _____ / _____ / _____ AGE: _____
MM DD YY

FIRST NAME: _____ TITLE CODE: MISS MRS. MR. MS. DR.

STREET: _____ MARITAL STATUS: SINGLE / MARRIED / OTHER

CITY: _____ EMPLOYMENT STATUS: Full Time/Part Time/Retired
Homemaker/Student

STATE: _____ ZIP: _____

HOME TELEPHONE : _____ FAMILY PHYSICIAN: _____

WORK TELEPHONE: _____ HOW DID YOU FIRST HEAR ABOUT OUR OFFICE? _____

EMPLOYER: _____

OCCUPATION: _____ WHAT NAME DO YOU PREFER TO BE CALLED? _____

SEX: M or F

SOCIAL SECURITY #: _____ METHOD OF PAYMENT: CASH / CHECK / CHARGE
(Circle One)

EMAIL ADDRESS: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

SOCIAL SECURITY NUMBER: _____

FINANCIAL POLICY

- Payment is due when services are rendered and before materials are ordered. Any exceptions must be approved in advance and finance charges (18%) will apply.
- Default of payment will subject account to all collection fees including court cost and attorney fees if applicable.
- We are glad to assist you in filling out your insurance forms, however, you are responsible for all professional charges at the time of service.
- Returned checks are processed through Check Collect. A \$25 service charge will be applied by Check Collect.

INSURANCE INFORMATION

Name of Vision Insurance: _____

Primary Insured: _____

Primary Insured's Employer: _____

Primary Insured's Social Security Number: _____

Primary Insured's Date of Birth: _____

INSURANCE AUTHORIZATION

"I hereby authorize the Swift Creek Eye Center to furnish information to insurance carriers concerning my treatment."

Patient or Representative Signature and Date

Please Print Patient or Representative Name

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed on the **Notice**. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way."

Patient or Representative Signature and Date

Please Print Patient or Representative Name