



Thank You For Choosing Our Office!

www.tmseyecare.com

2251 North Woodlawn, Wichita, KS 67220

2720 East 21st Street, Wichita, KS 67214

2508 Edgemont Dr. Ste 6, Arkansas City, KS 67005

Patient Information

(please print)

Name _____ Nickname _____ DOB ____/____/____

Marriage Status (married) (single) (divorced) Age _____ Sex M / F Social Security # _____ - _____ - _____

E-mail _____ Address _____

Apt # _____ City/State/Zip _____

Home phone # (_____) _____ - _____ Daytime Phone # (_____) _____ - _____

Emergency contact – name and phone _____

Spouse/parent name and phone _____

Who is responsible for account? _____

Relationship to Patient _____ Address / City / State / Zip **Same as above? Y / N**

If No: _____

Primary insurance co. _____ Insurance ID# _____

Policy /group # _____ Group/Employer's name _____

Policy holder's address (if different from above) _____

Relationship to policy holder _____

Policy Holders Social Security # _____ - _____ - _____ **Policy holder's DOB** ____/____/____

Secondary insurance co. _____ Insurance ID# _____

Policy /group # _____ Group/Employer's name _____

Policy holder's address (if different from above) _____

Relationship to policy holder _____

Policy Holders Social Security # _____ - _____ - _____ **Policy holder's DOB** ____/____/____

Whom may we thank for referring you? _____

Regarding Insurance We will do all we can to find out what your insurance benefits are and what you are eligible for. We will also submit your claim for you. The information given to us by your insurance company is not a guarantee of payment from them. If the insurance company does not pay this amount it will be your responsibility to pay your balance.

We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. It is your responsibility to provide your insurance company with correct information at all times and to be aware of your policy's benefits. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Our Financial Policy Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. All patients must complete our insurance and personal information forms before seeing the doctor. Payments for professional services and co-payments are due upon completion of the examination. Complete payment is due when any materials are received. There is a \$30 service charge on all returned checks.

Authorization I hereby authorize payment of my medical and vision benefits to Tran, Majher & Shaw, O.D., P.A. Doctors of Optometry. I understand I am financially responsible for any charges whether or not paid by said insurance. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Tran, Majher & Shaw, O.D., P.A., Doctors of Optometry at the time of service. I authorize Tran, Majher & Shaw, O.D. P.A. Doctors of Optometry to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original

Signature of Patient (or guardian)

Date