Welcome, and thank you for choosing our office!

Patient information:

Name: _____ Nickname: _____ Date of birth: ____/_____/_____

Sex: M/F Marital status (single, married, divorced, widowed) Social Security #:_____

Address: _____City, State, Zip: _____

Phone #: _____ (cell/home) Cell/alternate #_____

Email: _____ May we use text &/or email to contact you? _____

How did you hear about our office? /Whom may we thank for referring you? _____

Employer and occupation: _____

Family physician/address: _____

Preferred pharmacy/address: _____

Emergency contact name/phone: _____

Parent or spouse name/phone: _____

Children's names: _____

Who is responsible for the account? _____ Relationship to patient: _____

Address (if different than above): _____

City/State/Zip: _____ Phone (if different than above): _____

Information required for us to file your insurance claim:

Primary Insurance Company: _____ ID#_____

Policy/Group# _____ Group/Employer's Name: _____

Policy holder's info (if different from above): Name _____ DOB ____/_____/_____

Address: _____City/State/Zip: _____

Secondary Insurance Company: _____ ID# _____

Our Financial Policy

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Your assistance in completing the Patient Information Sheet in full is required in order to file your claim and the information you provide is kept confidential. Please provide us with a current copy of your medical insurance card(s) for your records.

Regarding insurance:

We will contact your insurance plan to verify benefits 24 hours before your scheduled appointment. Please be advised that this verification is only a quote from your insurance company and not a guarantee of payment. You are responsible for co-pays, co-insurance, deductibles and any fees for services not covered by your plan. Payment for co-pays and non-covered services are due upon completion of the examination and cannot be waived as this is a violation of our contract with your insurance company.

Payment:

We accept VISA, MasterCard, Discover, American Express, Cash and money order or personal checks. Please note that there is a $35.00 service charge for returned checks.

Authorization:

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

Signature of Patient/Guardian: _____ Date: _____

If parent/guardian signed as responsible party please print name: _____

(If the patient is under 18 years old, the parent or guardian must sign as the responsible party.)