

WELCOME TO
HOFFMAN EYECARE

Date _____
Title _____ First _____ Mid Initial _____ Last _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Home Ph _____ Work Ph _____ Cell Ph _____
Employer (or School) _____ Social Security # _____
Occupation (or grade) _____ Marital Status _____ E-Mail _____

Emergency Contact: _____ Phone _____ Relationship _____
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Insurance & Billing Information

Eye Insurance: VSP <input type="checkbox"/> Other _____	Health Insurance _____
Patient's ID# _____	Patient's ID# _____
Group # _____	Group # _____

If the primary insured is other than the patient, please complete the following:

Name _____ Date of Birth _____ Social Security _____
Address _____ City _____ State _____ Zip _____
Employer _____ Phone _____ Relationship to Patient _____

How did you first hear about our office?

Referred by:

Another Patient _____ Another Doctor _____
 Direct mail Yellow Pages Provider directory (which one) _____
 Web Site Other _____

- I understand that I am responsible for any amount not covered by my insurance company including any co-payments.
- I understand that professional *and* material fees, after applied insurance benefits, are due at the time services are rendered.
- I understand and agree that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in reimbursement from my insurance company.
- I authorize that insurance payment be made directly to Hoffman Eyecare and be credited to my account upon receipt.
- I authorize Hoffman Eyecare to release any information required to process any insurance claims.

FOR VSP PATIENTS: By signing this form, I am allowing my medical information to be released upon VSP's request, to VSP for the purpose of health care operations (including but not limited to, provider review functions, claims payment and quality assessment) I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing For information on VSP Confidentiality Policy refer to: www.vsp.com
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Signature _____ Date _____
Parent or guardian if patient is a minor