RANCHO SANTA FE
OPTOMETRY

NEW PATIENT INFORMATION FORM

Last Name _____ First Name _____

Nickname _____ ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Mailing Address _____

Street Address (if different) _____

City _____ State _____ Zip _____

Daytime Phone _____ Cell Phone _____

Email Address _____

Date of Birth _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number _____

Employer _____ Occupation _____

How were you referred to our office? Family ☐ Friend ☐ Online Search ☐

Referred Name *(so we can thank them)* _____

Meaningful Use *is using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities, engage patients and family, improve care coordination, and public health and to maintain privacy and security of patient health information.* ***Please fill out the following information, so we are in compliance with these standards:***

Preferred Language ☐ English ☐ Other _____

Race ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ Pacific Islander ☐ Caucasian ☐ Declined to Specify

Ethnicity ☐ Hispanic/Latino ☐ Pacific Islander ☐ Not Hispanic/Latino

Communication Preference ☐ Email ☐ Postal ☐ Telephone ☐ Text

Primary Care Physician (PCP) _____

Would you like a report of your exam sent to your PCP? ☐ YES ☐ NO

Please be prepared to share your health and eye history with doctors and staff at Rancho Santa Fe Optometry. Please bring all current eye wear, contact lenses and a list of your current medications.

Rancho Santa Fe Optometry accepts ***Vision Service Plan, Medical Eye Services and Medicare*** *insurance plans. If we are not provided with complete information for these providers at the time of service, you are responsible for payment in full with no guarantee we can bill for services rendered in the past.*

_____
(Initial)

VISION INSURANCE (VSP and MES ONLY)

☐ *Patient has no vision insurance*

☐ Medical Eye Services ***(MES)*** ☐ Vision Service Plan ***(VSP)***

Identification Number/Unique ID Number _____

Insured Party Full Name _____

Date of Birth _____ SSN#: _____

Relationship to Insured _____

MEDICARE

ID No. _____

Name *(EXACTLY as it appears on Medicare Card)*: _____

Do you have a Medicare supplemental insurance plan? ☐ YES ☐ NO

Supplemental Insurance Plan Provider _____

ID No. _____ Group Number: _____

CONSENT FOR TREATMENT, TO RELEASE INFORMATION & PAYMENT AGREEMENT
I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at the office of Rancho Santa Fe Optometry. I have received a copy of the privacy statement of Rancho Santa Fe Optometry.

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

Signature of Responsible Party _____ Date _____