NEWCASTLE VISION CLINIC
PATIENT INFORMATION FORM

Patient information - please print clearly **Today's Date: _____**

Full Name: _____ Male / Female

Address: _____ City, State, Zip: _____

Social Sec #: _____ Birth date: _____ Age:_____

Home phone: _____ Work phone: _____ Cell: _____

Best way to contact you: Home Work Cell Email Marital Status: Single Married Divorced Widowed

Hobbies: _____

Occupation: _____ Email: _____

Emergency Contact/Relationship: _____Phone #:_____

Who may we thank for referring you to us? _____

Would you like to opt out of all email correspondence? Circle Y / N

Would you like to opt out of all texting correspondence? Circle Y / N

Please list anyone you would like to have access to your account on your behalf:

Name_____ Relationship to patient_____ Initial _____

Responsible Party (if different from above)

Name of person responsible for account if not the patient:_____

Address: _____City, State, Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Employer: _____ Relationship to patient: _____

Insurance Information

Insurance: _____ Group #: _____

Subscriber: _____ ID #: _____

Patient's relationship to subscriber: Self Spouse Child Dependant

Subscriber's employer: _____ Subscriber's date of birth: _____

Please read and sign below

We will be happy to bill your insurance for you as a courtesy provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. All copays are due at time of appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible to pay for those office fees. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager or any other staff members, not with the doctor. I acknowledge that I have completed all of the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third party payers and/or other health practitioners if needed. **I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given. Any eyewear returns or exchanges may be subject to a restocking fee.**

Signature: X _____ Date: _____