

Frontier Vision Clinic, P.C.
Patient Information

Patient Name _____ Birth date ____/____/____ Gender: M/F
Address: _____ City/State/Zip _____
Phone # (Home): _____ (Work): _____ Soc. Sec # _____
Employer's Name: _____ Phone # _____
Address: _____ City/State/Zip _____
Nearest Relative not living with you _____ Phone # _____
Address _____ City/State/Zip _____

YOUR INSURANCE INFORMATION

Name of Insurance Company _____ Telephone _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Relationship to Insured _____
Insured Telephone Number _____ Insured Group Name _____
Insured Social Security # _____ Patient SS# _____ Group/Policy Number _____
Secondary Insurance Company _____ Telephone _____
Address _____ City _____ State _____ Zip _____
Insured Telephone Number _____ Insured Group Name _____
Insured Social Security # _____ Patient SS# _____ Group/Policy Number _____

I hereby assign my insurance benefits to be paid directly to Robyn L. Peterson, O.D., Brett A. Pexton, O.D. and/or Frontier Vision Clinic. I agree to be responsible for payment of all services rendered on my (my dependant's) behalf. I understand that PAYMENT IS DUE AT TIME OF SERVICE. Any amounts not received upon said date may be subject to a 1.5% month fee (18% APR). I agree to pay all costs of collection, including attorney fees, court costs, filing fees, including charges or commission, up to 50%, that may be assessed to us by a collection agency, or attorney retained to pursue this matter, with or without suit.

Patient Signature: _____ Date _____
Parent/Responsible Party Signature: _____ Date _____

The most convenient form of payment for me is: Check _____ Cash _____ Credit/Debit Card _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

(Must be age 18 or older)

Name (Last, First, MI) _____ Birthdate ___/___/___ Gender: M/F

Address _____ Years There _____

City _____ State _____ Zip _____ Home Phone _____

Social Security Number _____ Driver Lic. No. _____ Patient SS# _____

Previous Address _____ City _____ State _____ Zip _____

Patient or Parent Employer _____ Years There _____ Work Phone _____

Position _____ Employers Address _____

Spouse Name _____ Spouse Employment _____

I hereby authorize Dr. Peterson to examine, diagnose, and treat my (my dependant's) eyes and related structures with means necessary and agreed upon by me. Should further information be required, I give permission to request past medical records from health care providers and/or agencies.

Patient Signature: _____ Date _____

Parent/Responsible Party Signature: _____ Date _____

Dr. Peterson and Dr. Pexton suggest annual comprehensive eye health examinations. This may include many or all of the diagnostic tests listed below. If you desire that any of these tests NOT be performed, please indicate.

- ___ Dilating pupils allows for more complete health examination of the back of the eye
- ___ Blood pressure measurement aids in determining visual disorders
- ___ Tonometry is a measurement of internal eye pressure for possible glaucoma