Frontier Vision Clinic, P.C.

Patient Information

Patient Name: ____ Birth date _____/_____/______ Gender: M / F / Decline

Address: ____ City/State/Zip: ____

Phone # (Home): _____________________ (Cell): _______________________ Soc. Sec # (Optional) ________________________

E-mail: ____

Employer's Name: ____ Phone # ___________________________

Address: ____ City/State/Zip: _____________________________________

Emergency Contact: _________________________ Relationship to Patient: ____________Phone # ____________________

Address: ____ City/State/Zip:____

May we contact you for exam recall notices by one of the following (circle one): E-mail Postal Mail Do Not Contact Me

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YOUR INSURANCE INFORMATION

Name of Insurance Company ____ Telephone__________________

Address ____ City/State/Zip __________________________________

Name of Insured______________________________________ Relationship to Insured____________________________

Insured's Policy Number & Group Number & Group Name____

Insured's Social Security # _______________________________ Insured's DOB ___________________

Secondary Insurance Company____ Telephone__________________

Address ____ City/State/Zip _________________________________

Name of Insured______________________________________ Relationship to Insured___________________________

Insured's Policy Number & Group Number & Group Name____

Insured's Social Security # _______________________________ Insured's DOB ___________________

I hereby assign my insurance benefits to be paid directly to Robyn L. Peterson, OD, or Brett A. Pexton, OD, and/or Frontier Vision Clinic P.C. I agree to be responsible for payment of all services rendered on my (or my dependant's) behalf. I understand that I may be responsible for a co-payment in accordance with my insurance. I understand that **PAYMENT IS DUE AT TIME OF SERVICE or in accordance with the due date posted on any statements I receive from Frontier Vision Clinic, P.C.** Any amounts not received upon said dates 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 Frontier Vision Clinic, P.C. 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/ PARENT OR GUARDIAN

(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 or Dr. Pexton 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