Frontier Vision Clinic, P.C.
Patient Information

Patient Name _____ Birth date _____/_____/_____ Gender: M/F

Address: _____ City/State/Zip _____

Phone # (Home): _____ Cell #: _____ Soc. Sec # _____

E-mail Address: _____ Is it okay if we contact you by e-mail for exam recall notices? Y / N

Employer's Name: _____ Phone # _____

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 Policy/Group Number_____ Insured Telephone Number_____

Group Name _____ Insured Social Security #_____ Insured's DOB_____

Secondary Insurance Company_____ Telephone_____

Address _____ City_____ State_____ Zip_____

Insured Policy/Group Number_____ Insured Telephone Number_____

Group Name_____ Insured Social Security #_____ Patient SS#_____

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, 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% monthly late 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 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 (a measurement of internal eye pressure for possible glaucoma)