Welcome to Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

Last Name | Sffx | MI | First Name | Preferred Name

Mailing Address | City | State | Zip | Day Phone

☐ **Yes. Text Authorized.**

Social Security # | Date of Birth | Home Phone | Cell Phone

Email Address | Permission to email? ○ Yes ○ No

Employer | Person Responsible for Account

Emergency Contact | Emergency Contact Phone | Parent/Guardian Name

Race

☐ American Indian or Alaska Native ☐ Declined to specify
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
Other Race

☐

PRIMARY CARE PHYSICIAN

Height ft inch
Weight

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Declined to specify

Preferred Language ○ English Other Language: _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company M☐ F☐ | Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth | Insured's Employer

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company M☐ F☐ | Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read: I understand that the patient's portion is due at the time services are rendered. I understand that the refraction is a non-covered service by Medicare, AARP, Medicare Advantage, and any secondary Medicaid insurance. The patient will be held responsible for any balance due if insurance benefits are not coordinated properly. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize payment of insurance benefits to Jay K. Honda, O.D. I authorize the use and disclosure of my protected health information for the purposes treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices, which was provided to me. I understand that accounts 60 days past due are subject to collection fees of up to 50% of the original bill. I understand that there will be a service charge of $35 on all returned checks and $45 for appointments not canceled or rescheduled without a 24 hour notice.

○ Welcome Form Updated in Filemaker

Signature of Patient or Legal Guardian | Date