224 East Bearss Avenue
Tampa. Florida. 33613
Phone: (813) 443-2138
Fax: (813) 443-2139

5537 Sheldon Road, # A.
Tampa. Florida. 33615
Phone: (813) 806-0812
Fax: (813) 249-2049

Patient Database – Personal Information

Last name ____________________ **First name** ____________________ **MI** _____ **Other Names**_____________

Address __________________________________ City ____________________ State __________ Zip _________

Home Phone (_____)______________ Work phone (_____)______________ Cell Phone (_____)______________

E-mail address (needed for contact lens orders) ____

DOB ___________________ SS # _______________________ Drivers License # __________________________

Employer ____Occupation _______________________________

How did you find out about us? ___________________________ Who referred you? _____________________

Emergency contact name _________________________________ Phone number (_____)__________________

If Patient is a Minor, parent or guardian name(s): ____

Parents Drivers License # _______________________________________ Parent SS#:_______________________

Please Note: Children must be escorted by parent/guardian at all times. Guardians must present documentation.

Insurance Information:

Name of **VISION** Insurance ______________________________Member/Subscriber ID # ____________________

Name of the Primary Member: ____________________________SS# of Primary Member ____________________

Name of **MEDICAL** Insurance ____________________________Member/Subscriber ID # ____________________

Name of the Primary Member: ____________________________Primary Member Employer__________________

Patient Responsibility Statements, HIPAA and Consent to Treat

- I consent to optometric and optical services (including medical examination) at I-Care Optical
- I have read and understand the office policies of I-Care Optical
- I understand that I will be held financially responsible for payment of all charges incurred upon completion of the optometric examination at I-Care Optical, including the doctors time, services, contact lens fitting and materials
- I understand that insurance co-payments must be made at the time of the examination.
- I understand that insurance eligibility is not a guarantee of payment and if my eligibility cannot be verified, or have not met my deductible, or the claim is denied, I will be held responsible for full payment.
- I understand that I will be responsible for costs incurred in the collection or litigation of any unpaid balances. Past due accounts are subject to finance charges, collection agency fees and reporting to credit bureau.
- I understand that I-Care Optical is committed to protecting my identity and my privacy
- I acknowledge that I am aware of the Notice of Privacy Practices for I-Care Optical. I understand that in the course of providing medical and optometric services it is necessary to create and store health information. This information may need to be disclosed to other health related professionals during treatment, billing or referral.
- I authorize this office to release any information necessary to expedite insurance claims and the use of signatures on this form for insurance claim submissions and for payment to be made directly to my Doctor.
- I understand that if I require prescriptions or medical records I will be asked to sign a records release form and present photo identification. Copies of records are only provided to the patient (or parent who accompanied the child and signed consent). If you require another person to have access to your records (or your child's records) please write their name below.
- I give permission to ____to access to my (my child's) records
  Family/Friend who can Access my records

Signature of Patient/Parent/Guardian: _______________________________________ **Date**: ______________

This information is protected and confidential. A copy can be made upon request.

Developed by I-Care Optical 8/2009 (Rev 5/29/2012)