Welcome Form
Sacco Eye Group

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Father/Reverend ❑ **MALE** ❑ **FEMALE**

PATIENT'S Last Name:_____ First:_____ MI:_____

Address:_____ City:_____ State:_____ ZIP:_____

Date of Birth:_____ / _____ / _____ *(mm/dd/yyyy)* Social Security No:_____ - _____ - _____

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Email:_____

Name of Parent or Guardian if under 18

Name:_____ Home Phone: ( )

Address:_____ City:_____ State:_____ ZIP:_____

Date of Birth:_____ / _____ / _____ *(mm/dd/yyyy)* Social Security No:_____ - _____ - _____

Primary Medical Insurance Information

Primary Insurance:_____ Policy Holders Name:_____

Policy Holder Date of Birth:_____ / _____ / _____ *(mm/dd/yyyy)*

Secondary Insurance Information

Primary Insurance:_____ Policy Holders Name:_____

Policy Holder Date of Birth:_____ / _____ / _____ *(mm/dd/yyyy)*

VISION Insurance Information (i.e. VSP, EyeMed, Superior Vision…etc.)

Insurance:_____ Policy Holders Name:_____

Policy Holder Date of Birth:_____ / _____ / _____ *(mm/dd/yyyy)*

PLEASE READ CAREFULLY:

The patient's portion of the bill is due at time of service. It is the patient's responsibility to know their insurance coverage and to obtain any necessary referrals prior to examination and treatment. Sacco Eye Group will only submit bills to insurances with which we participate. We will not submit to your insurance if you do not provide a current insurance card. We will gladly provide you with an itemized statement for submission to your insurance for direct reimbursement if we do not participate with your insurance plan.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits to be paid directly to Sacco Eye Group. I understand that any unpaid balance on my account may be turned over to outside collection agencies and I am responsible for the balance and any fees incurred by that agency.

I agree to the terms and conditions of this statement: _____ Date:_____