Welcome to our office-Dr. James F. Matthews

Name:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Tel: Home:_____Work:_____Cell:_____

Married O Single O Divorced O Widowed O Email:_____

Date of Birth:_____Age:_____ Sex: M or F Social Security #:_____

Employer:_____Occupation:_____

Race: (circle) White O African -American O Asian O Latin O Other_____ Are your pregnant? Yes O No O NA O
Are you nursing? Yes O No O
Date of Last Eye Exam:_____Last Eye Dr._____

Date of Last Medical Exam:_____ Name of Dr._____Ph#:_____

How did you hear about our office: Please circle-> Friend O Family O Wal-mart O Optical Insurance O Web-site O
Are you interested in starting or continuing contact lens wear? Yes O No O
There are extra charges for contact lens fittings and yearly contact lens evaluations. We will discuss these with you.
Who may we thank for referring you?_____
Name of Person responsible for payment:_____Date of Birth_____
Address: (if different than above)_____
City:_____State:_____Zip:_____
Phone:_____Cell:_____Relationship to patient: _____
_____
How will you settle your account today? Cash O Credit Card Visa/MC O Debit Card Visa/MC O

Office Policies and Signature on File to allow us to bill your Insurance Company:
If you have any questions regarding using your insurance please ask us prior to your exam. Any insurance or discount program must be presented to the receptionist prior to the exam. Some insurances we do not accept, others need prior approval from the insurance company prior to your being seen. We want you to know what your obligations and co-pays are prior to the visit. If you present the information after the visit we have the right to not accept it and you will be responsible for full payment at the time of the visit. You are also ultimately responsible for all charges for which your insurance company denies payment when we receive an explanation of benefits statement from them.

I ,_____authorize James F. Matthews OD PA to mark the selection, “Enrollees or authorized person’s Signature” with the notation “Signature on File”. This section authorizes:

1. The release of any medical information necessary to produce this claim.
2. The release of any medical information from outside sources which may assist in my diagnosis and treatment.
3. James F. Matthews O.D. P.A. to file insurance claims on my behalf of services rendered.
4. Payment of medical benefits to be paid directly to James F. Matthews O.D. P.A., the Provider of the services herein described.

This authorization has been explained to me and I understand the office insurance policies.

_____ Date:_____
Signature

Please list any family members or friends who have permission to discuss your eye health with Dr. Matthews or any other members of his staff:

1._____Relationship:_____Ph. #_____

2._____Relationship:_____Ph. #_____

3._____Relationship:_____Ph. #_____