Welcome To Our Office

ADVANCED EYE CARE CENTER

Dr. George K. Johnson

Optometrist

Date ________________________

Patients Name ____ DOB ____________________

Address ____

City ___________________ State _________ Zip___________ Social Sec#_____________________

Home Phone ___________________________ Work ___________________________ Ext_________

Employer____________________________________ Occupation _____________________________

Medical Insurance ____ [ ] ***PPO*** or [ ] ***HMO***

Primary Insured Name ____ DOB ____________________

ID# ____ ***Relation to Patient*:** Self, spouse, parent, other

Who may we ***Thank*** for your referral ____

We invite you to participate in our online system. Features include:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

If ok please initial__________

Cell_______________________________ Email____

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I authorize payment of my benefits directly to ***Advanced Eye Care Center*** for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.
I understand that some services and procedures may not be covered by my insurance carrier. Fees not paid by my insurance carrier will be my responsibility.

This authorization is in effect until I choose to revoke it.

Signed ____ Date _____________________

I Acknowledge I have been offered/received a copy of this office's Notice of Privacy Practice.

Signed ____ Date _____________________