



2160 Penfield Road
 Rte. 441 & 250
 Penfield, NY 14526
 (585) 377-7090
 (585) 377-3155 (Fax)

Thank you for choosing Eyesite for your eye care needs. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Patient Information:

Today's Date ___/___/___

Name _____
Last First M.I.

Date of Birth: ___/___/___ Social Security # _____ Sex: Male Female

Address: _____

Home Phone: () _____ Cell Phone: () _____
City State Zip

Employer: _____ Phone: () _____

Primary Care Physician: _____ Phone: () _____

Parent, Spouse, or Responsible Party (if different from patient)

Name: _____ Date of Birth: ___/___/___
Last First M.I.

Address _____

Home Phone: () _____ Work Phone: () _____
City State Zip

Insurance Coverage – primary:

Insurance Co. Name: _____ Policy Number: _____

Policy Holder (Insured): _____ Policy Holder's Date of Birth: ___/___/___

SS#: _____ Sex: Male Female

Employer: _____ Policy Holder's Relationship to Patient _____

Insurance Coverage – Secondary:

Insurance Co. Name: _____ Policy Number: _____

Policy Holder (Insured): _____ Policy Holder's Date of Birth: ___/___/___

SS#: _____ Sex: Male Female

Employer: _____ Policy Holder's Relationship to Patient: _____

Medical History:

Date of Last Eye Exam: ___/___/___ Eye Doctor _____

-Continues on next page-

Bruce R. Hankin, O.D.
 Justin J. Verrone, O.D.
 Ben P. Peters, O.D.

Do you or anyone in your immediate family have a history of the following: (please indicate, self, none, or which family member)

Diabetes: _____ Blindness: _____ Lazy Eye: _____
Cataracts: _____ Thyroid: _____ Allergies: _____
Glaucoma: _____ High Blood Pressure: _____ Other _____

Please list any medications that you are currently taking:

Do you have any drug allergies? _____

Reason for today's exam: _____

Authorization for Release of Medical Information to the Payer and Assignment of Benefits to the Physician

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Dr. Bruce Hankin, Dr. Justin Verrone, and/or Dr. Benjamin Peters. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian: _____ Date: ___ / ___ / ___

Office Financial Policy:

- All payments for services and procedures and materials are expected on the day of appointment.
- If co-pay is not made at time of service, there will be a fee of \$10 added onto the balance due.
- For your convenience, our office accepts payment in the form of Cash, Check, Visa, MasterCard, American Express, and Discover.
- There will be a fee of \$30 on all returned checks.
- If payment on a delinquent account has not been made within a three month period, the account will go into collections.
- In the event that your account is referred to a collection agency, you will be responsible for all fees incurred for the collection of your bill; this includes attorney fees, court costs, and collection agency fees.

As a courtesy, we confirm your insurance benefits the day before you come to the office. All insurances do not guarantee any information provided to us over the phone or by the internet. It is the patient's responsibility to be familiar with their insurance policy, covered and non-covered benefits, as well as frequency and limitations of their coverage. Insurance companies select certain services that they will cover, as a result, not all procedures are covered by every insurance. The patient/guardian is responsible for cost of eye care and/or eyewear not covered by insurance contract.

I have read and understand the above financial policy.

Signature of patient/guardian: _____ Date: ___ / ___ / ___

Direct all questions regarding bills, payments, or insurance coverage to our billing department, or your insurance carrier.