CHELSEA
eye care

Personal Information

Today's Date_____ DOB_____ SS# (for insurance billing)_____

Full name Dr. Mr. Mrs. Ms. _____ Preferred name _____

Gender _____ Email_____

Home Address_____

City, State_____ Zip_____

Cell phone_____ Work Phone_____ Home Phone_____

May we contact you by text? Yes No

Occupation_____ Employer/School_____

Whom should we thank for referring you?_____

Insurance Information

Vision Insurance_____Member#_____Group#_____

Person Insured_____DOB_____Relationship to patient_____

Primary(Medical) Insurance_____ Member# _____Group#_____
Person Insured_____DOB_____Relationship to patient_____

Secondary Insurance _____Member#_____Group#_____

Signature on File

I hereby authorize payment of Medicare and/or Medigap, or other health insurance benefits to Hartley Nichols Eye Care, LLC for professional services rendered. I authorize the release of any necessary medical information, including copies of medical records, for determination of payment of benefits. I understand Dr. Nichols accepts assignment for Medicare, Blue Cross, and certain other HMOs and PPOs with which she is affiliated, and that I am responsible for any deductions, co-pays and/or fees for non-covered services such as office visits without required referral, refraction fees, non-medically related office visits, deluxe frames not covered by any insurance/vision plan (when applicable) and contact lens fitting fees.

_____ _____

Responsible Party's Signature Date