Welcome to Picard Family Optical

Your New Home For Fashion Eyewear and Professional Service

Dr. Dennis M. Picard, Optometrist

Today's Date: _____

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Call me on my: ☐ Work Phone: _____

(Please list all phone #'s) ☐ Home Phone: _____

☐ Cell Phone: _____

Date of Birth _____ Sex: M F

Marital Status: ☐ Single ☐ Married ☐ Minor child ☐ Other

Occupation _____

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed

☐ Full Time College Student ☐ Part Time College Student

Employer _____

Address _____

_____

How did you hear about us?

☐ I am a previous patient of Dr. Picard ☐ Church paper

☐ Internet ☐ Insurance Company ☐ Sign ☐ Yellow Pages

☐ Referred by: _____

☐ Other: _____

Emergency Contact Name _____

Phone Number _____

Notice of Privacy Practices Acknowledgement of Receipt

I have received this office's notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice on request.

_____

Signature

_____

Relationship to patient

Billing and Insurance Information

Person responsible for payment _____

Relationship to Patient _____

SS # _____

Primary Vision Insurance Co. _____

Employer Providing Insurance _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Secondary Vision Insurance Co. _____

Employer Providing Insurance _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Primary Medical Insurance Co. _____

Employer Providing Insurance _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Secondary Medical Insurance Co. _____

Employer Providing Insurance _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Assignment and Release – Signature Required

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party Date

Insurance Disclaimer

As a courtesy to our patients, we are pleased to accept insurance assignment. However, it must be clearly understood that the "contract" is between you, the patient, and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.