Welcome to

Gilbert Family Eye Center

4915 E. Baseline Rd., Ste. 115
Gilbert, AZ 85234 (480) 279-4400

(To be updated at each appointment for insurance purposes)

Today's date______________

Last name ____________________________**First name**____________________**Middle**____________ **M / F**

Address____________________________________**City**________________ **State**_____ **Zip**__________

Telephone: Home ( )__________________**Work ( )**______________**Cell ( )**________________

DOB (patient) _______ **E-mail address** ____

Vision Ins.___________**Medical Ins.**_____________**Member name/ID#/DOB**____________________________

Patient's Occupation_______________________**Patient's Employer**__________________________

****How did you first hear about us?** Friend/family member (name) ____________________
Yellow Pgs____ Mail ad____Insurance website____Community directory____ Driving by____ Other___________

Catch eye problems before they surface. **Digital Retinal Imaging** is now available in our office. This new technology can help us find eye conditions (glaucoma, macular degeneration, and diabetic retinopathy, among others) earlier than previous methods, as well as monitor changes over time. The digital retinal imaging can be performed in minutes without dilating the eyes and does not affect your vision. *The doctors highly recommend both dilation and digital retinal imaging.*

Please initial one of the following:

_____ I prefer the digital retinal image today ($29)

_____ I prefer to have my eyes dilated today

_____ I prefer to come back another time for a digital retinal image ($49 at a later visit) or to have my eyes dilated

Any specific concerns/questions?____

Are you being seen for a contact lens exam? Yes_____ No______

If so, a contact lens evaluation and/or fitting will be required to obtain a prescription (**this includes annual prescription renewals**). This evaluation is not covered by most insurance plans, and can range anywhere from $55 to $175 depending on your prescription and lens type.

Acknowledgement of Receipt

I_______________________ have reviewed the notice of privacy practices for the office of Gilbert Family Eye Center. If I have any questions I will refer them to the staff at Gilbert Family Eye Center.

Patient (or Guardian) Signature:____________________ ***Date***________*Refusal to Sign (__)*

Patient Responsibility

I______________________ (patient name) understand that I am ultimately responsible for payment of all services provided for myself and my dependents by ***Gilbert Family Eye Center.***
I understand that if my eligibility cannot be verified or if I do not obtain the proper referral form when required, I will be financially responsible for payment of all charges incurred for services rendered by ***Gilbert Family Eye Center****.*
I authorize the use of my name on medical and vision insurance claims for services provided to me and my dependents. I authorize the payment of claims to ***Gilbert Family Eye Center.***

Signature of Patient (or Guardian): __________________________***Date*** ________