Welcome To Our Office

My staff and I thank you for having selected Dixie Eye Care to provide your personal eye care. In order to aid in the efficiency and accuracy of your personal and insurance information, please fill the blanks below.

Patient Full Name:_____ Date of Birth:_____

Preferred Name (if different):_____ Gender: M/F Soc. Sec.#____-___-_____

Address:_____City/State/Zip:_____

Home Phone: _____ Cell Phone: _____Day Phone:_____
Email Address: _____

Marital Status: Married___ Single___ Widowed__ Legally Separated___

Tobacco Use: Current Everyday ___ Former ___ Smokeless ___ Never ___

Employment Status:Full-time___ Part-time___ Part-time Student___ Full-time Student___
Retired___ Military Active Duty___ Not Employed___

Employer's Name:_____ Phone:_____

Employer's Address:_____ City/State/Zip:_____

Contact Not Living With You*:* _____ Phone: _____

Address: _____ City/St./Zip: _____

Reason For Today's Visit: _____ Referred By: _____

Are You Interested In: Glasses___ Contact Lenses___ Laser Vision Correction___

Last Eye Exam: _____ Known Eye Health Problems: _____

Family Vision History: Blindness__ Glaucoma__ Macular Degeneration__ Eye Turns/Strabismus__

Known Medical History: _____Family Doctor:

_____

Current Medications: _____ Allergies:

_____

Dr. Brent Croft and Dr. Michael Croft suggest annual comprehensive eye health examinations. This may include many or all of the diagnostic tests listed below. If you desire that any of these tests **NOT** be performed, please indicate.

____ **Dilating Pupils** ____ **Blood Pressure** _____ **Tonometry**

Responsible Party/Guarantor:_____Birth Date:_____

Gender M/F Address:_____ City/State/Zip_____

Phone (Home): _____ (Work) _____ (Cell)_____ Soc. Sec. _____

Primary Insured's Name: _____ DOB: _____

Insurance Name:_____ID #:_____

Sec. Insured's Name: _____ DOB: _____ Insurance Name:_____ ID #.

_____

Insured's address, if different from responsible party/Guarantor_____
City/State/Zip_____

Because your eye health and clear vision are our primary concern, the care and products recommended for you, are the same as we would recommend for a member of our own family under similar circumstances. We recognize that you have a choice in the selection of your eye care provider, and we will continually strive to ensure that your trust in us is justified.
Sincerely,
Dr. Croft

Patient Consent Form

I, _____
(Patient or Guardian)

Consent Dr. Croft to the release of medical records for the above specified individual to:

Insurances:_____

(Please Read Carefully): I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon my insurance's request to them for provider review, insurance claims payment, and quality assessment. In the event of surgical or medical referral, I also consent that my information will be released to appointed medical personnel or prescription centers (labs, pharmacies).

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I hereby authorize Dr. Croft to examine, diagnose, and treat my (my dependent's) eyes and related structures with means necessary and agreed upon by me. Should further information be required, I give permission to request past medical records from health care providers and/or agencies.

We make every reasonable effort to avoid misunderstandings which may arise regarding your account with this office and your insurance companies. We urge you to understand your contractual insurance benefits. Please remember that the insurance policy is between you and your insurance companies, not Dixie Eye Care or your doctor. Although we bill your insurance companies as a courtesy to you, the responsibility for payment is ultimately yours.

When a patient has a medical eye condition, we will bill his/her medical Insurance as the primary coverage before any vision riders are billed . I hereby assign my insurance benefits to be paid directly to Dr. Croft. I agree to be responsible for payment of all services rendered on my (my dependent's) behalf. I understand that PAYMENT IS DUE AT TIME OF SERVICE. Any amounts not received upon said date may be subject to a 1.5% monthly fee (18% APR). I agree to pay all costs of collection, including attorney fees, court costs, filing fees, including charges or commission, up to 50%, that may be assessed to us by a collection agency, or attorney retained to pursue this matter, with or without suit.

Patient/Guardian Signature: _____ Date: _____