Dixie Eyecare & CONTACT LENS CENTER
Brent L. Croft, O.D. • Michael S. Croft, O.D. • Jason F. Foote, O.D.
301 East Tabernacle, ste. 101
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435.673.3558
435.673.9181 fax

Welcome!

Thank you for choosing us for all your eyecare needs. In an effort to speed up our check-in process, we ask that you please text or email your current medical insurance cards to 435-673-3558 or dixieeeeycare@gmail.com and fill out the form below. Please include a picture of the front and back of your insurance cards as this will allow us to verify your benefits beforehand. Give us a call if you have any questions 435-673-3558. We look forward to seeing you at your appointment!

Sincerely,

The doctors and staff at Dixie Eyecare

Welcome To Our Office

Dear

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 verify your information below and fill any blanks.

Demographic Information

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: _____**What is your preferred method of contact? Text**____ **Call**____

Patient's Responsible Party/Guardian:_____**Birth Date:**_____

Gender M/F Address:_____ **City/State/Zip**_____

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

Patient Marital Status: Married___ **Single**___ **Widowed**__ **Legally Separated**___ **Divorced**___

Employment Status: Full-time__**Part-time**__**Part-time Student**__**Full-time Student**__**Retired**__**Military Active Duty**___ **Not Employed**___

Employer's Name:_____ **Phone:**_____

Emergency Contact Person 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:** _____

Insurance Information (please fill out to the best of your knowledge)

Primary Insured's Name:_____**DOB:**_____ **Ins. Name:**_____**ID #:** _____
Primary Insured's Address:_____**City/State/Zip**_____

Primary Insured's Phone (Home): _____ **(Work)** _____ **(Cell)**_____ **Soc. Sec.** _____

Secondary Insured's Name: _____ **DOB:**_____ **Ins.:** _____**ID #.** _____

Secondary Insured's Address:_____**City/State/Zip**_____

Secondary Insured's Phone (Home): _____ **(Work)** _____ **(Cell)**_____ **Soc. Sec.** _____

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, the Doctors at Dixie Eyecare

Patient Consent Form

I,
Consent the doctors at Dixie Eyecare to the release of medical records for the above specified individual to my 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:**