2160 Penfield Road
Rte. 441 & 250
Penfield, NY 14526
(585) 377-7090
(585) 377-3155 (Fax)

Bruce R. Hankin, O.D.
Justin J. Verrone, O.D.
Ben P. Peters, O.D.

Thank you for choosing Eyesite for your eye care needs. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Patient Information:

Today's Date___/___/___

Name____
Last First M.I.

Date of Birth:___/___/___ Social Security #______________________ Sex: Male Female

Address:____
City State Zip

Home Phone: ( )___________________ Cell Phone: ( )____________________

Employer:____ Phone: ( )____________________

Primary Care Physician:____________________________ Phone: ( )____________________

Parent, Spouse, or Responsible Party (if different from patient)

Name:____ Date of Birth:___/___/___
Last First M.I.

Address____
City State Zip

Home Phone: ( )__________________ Work Phone: ( )___________________

Insurance Coverage – ***primary:***

Insurance Co. Name:__________________ Policy Number:________________________________

Policy Holder (Insured):_________________________Policy Holder's Date of Birth:___/___/___

SS#:_____________________________ Sex: Male Female

Employer:__________________________ Policy Holder's Relationship to Patient___________

Insurance Coverage – ***Secondary:***

Insurance Co. Name:__________________ Policy Number:________________________________

Policy Holder (Insured):________________________ Policy Holder's Date of Birth:___/___/___

SS#:______________________________ Sex: Male Female

Employer:__________________________ Policy Holder's Relationship to Patient:___________

Medical History:

Date of Last Eye Exam:___/___/___ Eye Doctor_______________________________________

-*Continues on next page*-

Do you or anyone in your immediate family have a history of the following: (please indicate, self, none, or which family member)

Diabetes:_________________ Blindness:__________________ Lazy Eye:__________________
Cataracts:__________________ Thyroid:___________________ Allergies:__________________
Glaucoma:_____________ High Blood Pressure:_____________ Other____________________

Please list any medications that you are currently taking:

____
____
____

Do you have any drug allergies? ____

Reason for today's exam: ____

Authorization for Release of Medical Information to the Payer and Assignment of Benefits to the Physician

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Dr. Bruce Hankin, Dr. Justin Verrone, and/or Dr. Benjamin Peters. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian:___________________________ Date:___/___/____

Office Financial Policy:

- All payments for services and procedures and materials are expected on the day of appointment.
- If co-pay is not made at time of service, there will be a fee of $10 added onto the balance due.
-For your convenience, our office accepts payment in the form of Cash, Check, Visa, MasterCard, American Express, and Discover.
- There will be a fee of $30 on all returned checks.
- If payment on a delinquent account has not been made within a three month period, the account will go into collections.
- In the event that your account is referred to a collection agency, you will be responsible for all fees incurred for the collection of your bill; this includes attorney fees, court costs, and collection agency fees.

As a courtesy, we confirm your insurance benefits the day before you come to the office. All insurances do not guarantee any information provided to us over the phone or by the internet. It is the patient's responsibility to be familiar with their insurance policy, covered and non-covered benefits, as well as frequency and limitations of their coverage. Insurance companies select certain services that they will cover, as a result, not all procedures are covered by every insurance. The patient/guardian is responsible for cost of eye care and/or eyewear not covered by insurance contract.

I have read and understand the above financial policy.

Signature of patient/guardian:______________________________ Date:___/___/____

Direct all questions regarding bills, payments, or insurance coverage to our billing department, or your insurance carrier.