Blackstone Valley Eye Care, P.C.

Thank you for choosing Blackstone Valley Eye Care, P.C. for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Home Phone - Include Area Code _____ Day Phone _____

Guardian _____ Email Address _____

Emergency Contact _____ Emergency Phone _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

I request that payment of the authorized health insurance benefits be made to me or on my behalf to Blackstone Valley Eye Care, P.C. for any services furnished by the doctors and staff employed there. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges, whether or not paid by the insurance, for all services rendered on my behalf. The patient's portion is due at the time services are rendered.

Once Blackstone Valley Eye Care, P.C. has obtained my one-time authorization, they may submit any later insurance claims on either an assigned or non-assigned basis, without obtaining any additional signature from me. In submitting claims, they should indicate in the patient's signature space: "Signature on File."

In order to thoroughly examine the internal health of the eye, it may be necessary to dilate your pupil. This technique allows the doctor to observe the peripheral area of the retina that would otherwise be hidden from view. Dilation is accomplished through the use of eye drops. The drops' effects may last a few hours. You will experience blurred vision for reading and light sensitivity. Your distance vision will usually not be blurred, but may seem a little distorted. Complications from dilation are extremely rare. My signature below authorizes the doctors or staff at Blackstone Valley Eye Care, P.C. to dilate my eyes as needed. You will always be verbally informed prior to the use of dilation drops.

Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. There will be a $25 charge for any missed/canceled appointments without giving 24 hour notice to the office.

Patient or Guardian SIgnature _____ Patient or Guardian Name (Please Print) _____ Date _____