Sibia Eye Institute

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

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

Race
☐ American Indian Or Alaska Native ☐ Native Hawaiian Or Other Pacific Islander
☐ Asian ☐ White
☐ Black Or African American ☐ Declined To Specify
☐ Hispanic Or Latino
Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft in cm/m ○ ft in ◉ cm ○ m **Weight** ◉ lbs ○ kg

Who referred you to our office? _____ Emergency Contact _____ Emergency Phone _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company | Insured's First Name | MI | Insured's Last Name M ☐ F ☐

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

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

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company | Insured's First Name | MI | Insured's Last Name M ☒ F ☐

Please Read:

Dilating drops are used to enlarge pupils of the eye to allow your doctor to get a better view of the inside of the eye. If you are uncomfortable driving please make arrangements not to drive yourself. Be sure to wear sunglasses outside.
I understand that dilating drops are a necessary portion of the eye exam _____

Refraction must be done if you want to know if a new pair of glasses will improve your vision. Medical insurance, PPO's, HMO's, Medicaid or Medicare will not reimburse for the refraction. I understand that **REFRACTION** is a **NON-COVERED** service and that I am responsible for payment of **$40 AT THE TIME OF SERVICE** _____

Payment from my insurance is to be paid directly to Florida Eye & Plastic Surgery Associates, Inc.. I understand that my primary insurance may be billed. I understand that billing any secondary insurance may be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

We ask that the patient's portion is paid at the time services are rendered. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a $25 service charge on all returned checks.

I understand my rights regarding my medical records. A copy of Florida Eye & Plastic Surgery Associates, Inc. Notice of Privacy Practices has been made available to me. I authorize FEPSA to speak to _____ regarding my medical records.

Signature _____ Date _____