



EYEWEAR SHOWCASE

Dr Janice Bianchi Frederickson & associates

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TODAY'S DATE

FILL OUT COMPLETELY AND PLEASE PRINT

Patient's name Patients Birth Date Social Security Number Marital status Single ___ Married ___ Widowed ___ Divorced ___

Patients address City State Zip Home phone Cell phone

E-mail address If child, parent's name or guardian's name

Name of patients employer Address Business phone Occupation

Do you have Medical Insurance? Yes ___ No ___ Name of Insurance Co. Subscriber name and birth date Policy # Group#

Do you have Vision Insurance? Yes ___ No ___ Name Of Insurance Co. Subscriber name and birth date Policy # Group #

Person financially responsible for this account Address Relationship to patient

Name of Person we are permitted to share information with Relationship to patient Phone

Whom may we thank for referring you? Address

Please check your payment preference: ___ Insurance ___ Credit card ___ Check/cash

Payment is expected at the time services are rendered, including non-covered portions of insurance.

NOTE: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, Please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!!! I understand that financial responsibility for my account is mine, not my insurance company's.

SIGNED: _____

I authorize the release of any medical or other information to be given to my PCP or a referring Physician if it is required or helpful to my continued care/treatment. _____ Initial

I authorize the release of any medical or other information necessary to process the insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize the payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: _____

SIGNED: _____