CORONA OPTIQUE
2149 W. 24th Street • Yuma, Arizona 85364
PH: (928) 726-1100 • Fax: (928) 341-0881
www.coronaoptique.com

Welcome to CORONA OPTIQUE

PATIENT INFORMATION

PLEASE PRINT

Mr. Mrs. Ms. Miss (Please check one)

First Name: _____ Last Name: _____ M.I.: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: Home _____ Work_____Ext_____ Cell_____

E-mail Address: _____ Would you like to be added to our newsletter? ____Yes _____No

Social Security #:_____ Date of Birth: _____ Sex: Male Female

If under 18 years of age

Name of Responsible Parent or Guardian: _____

Insurance Information

Name of the Insured:_____ Insured's Date of Birth: _____

Insured's Social Security #: _____

Insured's Employer:_____ Insured's Employer Phone #: _____

Insurance Company Policy #: _____

Insurance Agreement and Release

I, the undersigned certify that I or my dependent have insurance coverage with the above Insurance Company and assign directly to Corona Optique all insurance benefits, if any, otherwise payable to me for services rendered, I understand than I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date:_____

Medicare Authorization

I request that payment for authorized Medicare benefits be made either to me or on my behalf to Corona Optique for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I also understand that refractions for my eyeglass prescription is a non-covered service by Medicare and is my responsibility.

Signature: _____ Date:_____

Ocular History

Date of Last Exam: _____ Name of Doctor: _____

Do you wear glasses? Yes No If yes... all the time occasionally reading driving

Do you wear contacts? Yes No If yes... disposable daily tone gas permeable

Have you had surgery on your eyes? Yes No If yes... cataract other (please describe below)

_____

Which eye(s)? Right Left Both

Please list medications you are taking at this time:_____

_____

Please list any eye drops: _____

Please list any medications you are allergic to:_____

Authorization to Release Records

On April 14, 2003 a new Federal Law, HIPPA, went into effect to protect your personal health information (PID. If you need to authorize someone else to have access to your records in our office please list them and their relationship to you below. Please note, that under this new law we cannot release information to a spouse or a parent if the minor is 18 or older, regardless of who is responsible for the charges.

Name: _____ Relationship to you:_____

Name: _____ Relationship to you:_____

Name: _____ Relationship to you:_____

I hereby authorize Corona Optique to release my PHI to the listed individuals above until I submit a written request to withdraw them from having such access.

Signature of Patient: _____ Date: _____

Thank You

The Doctors and Staff at Corona Optique would like to thank you for trusting us with your vision needs.