Optometry by the Bay
Welcome To Our Office

Welcome to Optometry by the Bay. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you 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 Number ____ Date of Birth ____ Home Phone - Include Area Code ____ Work Phone ____

Email Address ____ Spouse or Parent(s) Name ____ Person Responsible for Account ____

I give my permission to receive Emails.
Initials ______

Emergency Contact ____ Emergency Phone ____

How were you referred to our office?

☐ Phone Book ☐ Google AD ☐ Advertisement ☐ Patient (Please Name) ____

☐ Insurance Listing ☐ Drive by ☐ Other ____ ☐ Doctor (Please Name) ____

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:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.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 service charge of $ 25 on all returned checks. Initials ________ Also there will be a $25 charge for missed appointments without 24 hour notice. Initials ________**

Payment from my insurance is to be paid directly to Optometry By The Bay. I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is 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.

Signature ____ Date ____