Tru-i-Care Welcomes You To Our Office

Family Eye Care Specialist

Patient Information

Last_______________________________________
First _______________MI_____________________
Marital Status______________________________
Street______________________________________
City ___________________State________________
Zip Code __________________Sex M F
Date of Birth ____________________Age________
Race _________________ Ethnicity______________
Height__________Weight__________BP________
Patient's SSN________________________________
Occupation__________________________________
Employer____________________________________

Please mark preferred method of communication
___Cell Phone ______________________________
___Home Phone______________________________
___Work Phone ______________________________
___Email Address____________________________

What is the major purpose of this visit? Any problems with your current contact lenses or glasses?
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VERY IMPORTANT! NEW PATIENTS ONLY:
How Did You Choose Our Office?
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Who may we thank for referring you to our office?
Name of friend or relative________________

INSURANCE

Subscriber Name_______________________________
Birth Date_________________SSN_______________
Relationship to patient__________________________
Employer_____________________________________
Work Phone number____________________________
Vision Insurance______________________________
ID#____
Plan/Group#__________________________________
Primary Medical Insurance______________________
ID#____
Plan/Group#__________________________________

Do you participate in a flex spending account? ❑ Yes ❑ No

**There will be a $30.00 charge for returned checks.*
**Please note that insurance MAY not cover the Contact Lens Follow up Evaluation*

Today's Date___________________________________

The mission of Tru-i-Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality of vision care. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority.

Tru-i-Care is committed to making your visit a pleasant experience. Tru-i-Care would like to leave messages regarding appointments, pick-up of glasses and or contacts by the method indicated by "preferred method of communication". If this is not acceptable please indicate Type to enter text the best method to contact you here.
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Tru-i-Care will follow the guidelines established by HIPPA. By signing below you are acknowledging that you have read and/or been offered a copy of our HIPPA policies.

As a courtesy, Tru-i-Care will be glad to file the insurance forms for you. Since insurance companies can deny or do not cover the full amount for exam services and materials, you will be responsible for full payment of doctor services and vision materials (frames, lenses, and contacts) at the time of your visit.

In the event, the patient or responsible party fails to meet their obligation, Tru-i-Care reserves the right to disclose such information to the collection agency or attorney as required to fulfill all financial obligations. Such disclosure or re-disclosure shall not be a breach of the patient's confidentiality by Dr. Davis or Tru-i-Care.

I do authorize Dr. Davis to release written and/or verbal information from my records to process my insurance claims and as needed for referrals and treatment.
By signing, I agree and comply to all of the above:

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Date____