



Welcome to Meridian Family Eyecare!

Dan C. Thieme, O.D.

Today's Date: _____

Patient Information:

Last Name _____
 First _____ Middle _____
 Street _____
 City _____ State _____ Zip _____
 Email _____
 Home phone _____ Work phone _____
 Cell phone _____
 Preferred contact method: cell / home phone / work phone email
 Male / Female Date of Birth _____ Age _____
 Single / Married / Divorced / Widowed
 Employer (or school) _____
 Occupation (or grade) _____
 Hobbies / Interests _____
 Social Sec # _____

Guarantor _____ Spouse _____ (check one)

Relationship: _____
 Last Name _____
 First _____ Middle _____
 Street _____
 City _____ State _____ Zip _____
 Email _____
 Home phone _____ Work phone _____
 Cell phone _____
 Preferred contact method: cell / home phone / work phone email
 Male / Female Date of Birth _____ Age _____
 Single / Married / Divorced / Widowed
 Employer (or school) _____
 Occupation (or grade) _____
 Social Sec # _____

Preferred payment method: Cash / Check / VISA-MC / CareCredit

Primary Medical Physician: _____ Address: _____
 Vision Insurance _____ Primary Health Insurance _____
 Secondary Insurance _____ **Please provide insurance cards.**

Financial Agreement:

I understand that payment is due and expected at the time of service. This includes deductibles, co-payments, co-insurance and other non-covered charges.

I understand that my insurance will be billed as a courtesy, and that I am responsible for any and all charges not covered by my insurance. I understand that all insurance cards must be presented at the time of service. If I do not provide all my insurance cards at the time of my initial service, then this office has no responsibility to submit insurance claims on my behalf. If insurance information is not provided by me at the initial visit, any insurance filing will be my responsibility.

I understand that my insurance may disallow some charges and that these amounts are my responsibility.

I understand that I am responsible for any referrals or prior authorizations required by my insurance company for payment to be made on my claims. If I do not obtain prior authorization and payment is denied by my insurance carrier because of this, all balances will be my responsibility.

I understand that I will be responsible for any attorney's fees, court costs and/or collection fees added to my account if it becomes necessary to refer my account to an outside source for collection.

Signature _____ Date _____

Print name _____