Michael Diffendall, OD.
Johanna Letts, OD.
Barry Weiner, OD

JACKSONVILLE eye care

Name: Mr/Mrs/Ms/Dr_____ Jr/III Date: _____

Nickname: _____ DOB: _____

Address: _____ Sex: _____M / F_____

City : _____ State: _____Zip: _____

Phone (home): _____ (work): _____ (mobile): _____

Patient Employer: _____Occupation: _____

Email: _____

How did you hear about us? _____
Who may we thank for referring you? _____

Vision Insurance
Insurance Carrier Name: _____
Member ID: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy Holder DOB: _____ Policy Holder SS# (last 4 digits) XXX-XX-_____

Primary Medical Insurance
Insurance Carrier Name: _____
Member ID: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy Holder DOB: _____ Policy Holder SS# (last 4 digits) XXX-XX-_____

Financial Policy:
Insurance coverage is an agreement between the member and their insurance company. As a courtesy we will attempt to obtain an authorization for services prior to your appointment and submit these claims to your insurance company.

This authorization is not a guarantee that services will be paid. It is ultimately your responsibility to understand the conditions of your particular plan, and you are financially responsible for any services not paid by your insurance company. Additionally, you authorize and request that insurance payments be paid directly to **Jacksonville Eye Care**.

Privacy Practices:
I hereby authorize the release of any medical or personal information necessary to process insurance claims.

Please note: At this time we do not file secondary insurance claims.

Signature on File:

Signed: _____ Date: _____