WELCOME TO THE OFFICE OF DR. FRED BRECHEEN

TODAY'S DATE_____

_____/___/_____

Last First Birthdate Age

Mailing Address City State Zip

Residence Phone Cell Phone Daytime Phone

Email Address

Vision Insurance Member (VIM) VIM Date of birth VIM last 4 digits of SS# Name of Vision Insurance

Referred by Date of last eye exam Previous eye doctor

Medications including mg: Condition taken for:

_____ _____

_____ _____

_____ _____

_____ _____

Any known allergies? If so, please list:_____

Dilation Drops or Camera

Dr. Brecheen normal dilates all patients over the age of 25. You now have a choice of being dilated or using the camera. Your insurance normally covers dilation but not the camera. The advantage of the camera is that it gives Dr. Brecheen a much larger view of the back of your eye, and we can compare your pictures each year. If you would prefer the camera rather than the eye drops, ***you will be charged $31.00*** which is not covered by insurance.

Please check if you want eye drops or the camera.

Eye drops _____

Camera _____

I authorize the release of any medical or other information necessary to process any claims arising from the services and materials provided. I also request payment of private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage. I have read and/or have been provided a copy of Notice of Privacy Practices.

Signature Date