WELCOME TO OUR OFFICE

Thank you for selecting our office. To meet your vision care needs, please fill out this form completely. If you need any assistance or have any questions, please ask us – we will be happy to help.

PERSONAL INFORMATION

Name _____ **Date** _____

Birth date _____/_____/_____ **Age** _____ **SSN** _____/__ __/_ _ _ _

I wish to be called: Ms. Mrs. Miss Mr. Dr. Rev. Other_____

Male _____ **Female** _____ **Minor** _____

Parent, Spouse, Significant Other _____

Address: _____

City, State, Zip _____

Home Phone _____ **Work Phone** _____

Where do you prefer receiving calls H _____**W** _____**Cel** _____

e-mail _____ _____**Cel** _____

Employer (or School) _____**Occupation (or Grade)** _____

If you are wearing Contact lenses, who fit you _____

_____

Are you interested in Contact Lenses or Corrective Refractive Surgery _____

Have you received vision therapy? _____**When** _____

Whom may be thank for referring you _____

_____

Who should we contact in the event of an emergency? _____

Phone # _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Who is responsible for the account/Relationship _____

_____

DOB _____ **SSN** _____

Driver's License _____

Address _____

_____

Employer _____

_____

Occupation _____

Insurance Information _____

Address _____

_____

Secondary Insurance Information _____

_____

Authorization & Release

I authorize the release of any information, including diagnosis, and the records of any treatment or examination rendered to me or my child during the period of such care to 3rd party payers, insurance company, adjustor, attorney, educational institution, or other health providers involved in this case.
I authorize and request my insurance company to pay directly to this office, benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered to me or my dependents.
I authorize all routine or emergency vision care and services provided by this office and understand that I may withdraw my consent at any time by giving verbal or written notice.
I authorize this office to file a formal complaint on my behalf with the Department of Insurance or other appropriate agency if it becomes necessary as a result of any mishandling of the processing of my claim by any third party. I am responsible for all costs associated with collection or legal actions. All past due accounts (over 30 days) are subject to a finance charge of 1 ½% per month. If an account is sent to a collection agency, the fee will be 30% of the charge owed and will be added to the total amount due. All fees are due and payable at the time of service unless otherwise agreed upon. No records or prescriptions will be released until payment in full is received.

Signature _____ **Date** _____
(Patient, Parent, Guardian)

PREFERRED METHOD OF PAYMENT

Cash_____ VSP_____ MediCal_____ Medicare_____ Tricare_____ Blue Cross_____ Other_____