Insurance Information:

Do you plan on using insurance?

* Yes *(Please provide ID & Insurance card. Continue to next section)*
* No *(All self pay balances must be paid off on the day of service)*

Insurance Details

* Patient is Primary Subscriber on Insurance, as well as “Person Responsible” for payment
* Parent or Spouse is Primary Subscriber on Insurance

-Primary’s Name

-Patient Relationship to Primary       DOB

Medical Insurance:

Company      PPO HMO, Insurance ID#      , Ins Co Phone Number

Vision Insurance:

Company      , ID#/Last 4 of SS#      , Vision Ins Co Phone #

In any case that insurance does not pay for services rendered, please list “Person Responsible” for payment:

Primary subscriber listed above

Address, if different than patient:

Other:

Name      Relationship to Patient

Address

Phone Number

\*Due to increasing complexity of insurance plans and their unwillingness to assist us in helping verify vision insurance coverage, if we cannot obtain a vision exam authorization with the information you provide, payment for services will be the responsibility of the “Person Responsible” (indicated above).

Account balances:

*We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.*

Patient or Guardian Signature: Date: