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: