PATIENT INFORMATION (form must be complete)

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name ____________ (First) ____ (MI) ____________ (Last) Birthdate ________ Age ____

Check appropriate box: ☐ Minor ☐ Widowed ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Female ☐ Male   Social Security No ____________

Complete Home Address ____________________ Home Phone ____________

Email Address ____________ Work Phone ____________ Cell Phone ____________

Occupation ____________ Employment Status Check appropriate: __Full Time __Part Time __Retired __Student

Employer ____________ Complete Work Address ____________

Spouse/Parent Name ____________ Address ____________

Spouse/Parent Employer ____________ Address ____________ Work Phone ____________

Nearest Relative/Friend ____________ Relationship to Patient ____________ Phone Number ____________

Who referred you to us ____________ Family Doctor ____________ Phone Number ____________

BILLING AND INSURANCE INFORMATION

<u>Primary</u> Insurance Company Name ____________ ID or Policy Number ____________ Group/Code Number ____________

Insurance Company Address ____________ Date effective ____________ Subscriber's SS Number ____________

Subscriber's Name ____________ Subscriber's Date of Birth ____________ Relationship to Patient ____________

Subscriber's Address ____________ Home Phone ____________ Work Phone ____________

<u>Secondary</u> Insurance Company Name ____________ ID or Policy Number ____________ Group/Code Number ____________

Insurance Company Address ____________ Date effective ____________ Subscriber's SS Number ____________

Subscriber's Name ____________ Subscriber's Date of Birth ____________ Relationship to Patient ____________

Subscriber's Address ____________ Home Phone ____________ Work Phone ____________

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I certify the above information is correct. I hereby authorize payments of all medical insurance benefits which are payable to me under the terms of my insurance policy, to be paid directly to Insight Vision Center. I authorize the release of any information needed for processing my insurance. I understand that I am responsible to ensure payment for services rendered to me.

____________ Signature Patient/Guarantor/Guardian ____________ ____________ Date

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