Patient Information:

Patient Name: _____ Gender: M or F
Race: _____ DOB: ____/____/_____ SS#: _____-____-_____
Mailing Address: _____
City: _____ State: _____ ZIP Code: _____
Home Phone: (_____) - _____ - _____ Cell Phone: (_____) - _____ - _____
E-mail address: _____@_____.com
Employer: _____ Occupation: _____
Work Phone: (_____) - _____ - _____
Marital Status: Single Married Divorced Widowed
Name of Spouse: _____
If under 18, Parent/Guardian Name: _____
How did you hear about us? Internet search Yellow pages Walk-in
If referred by someone, what is their name? _____
Person responsible for account: _____

Insurance Information:

Name of Insurance: _____
ID#: _____ Group #: _____
Secondary Insurance: _____
ID#: _____ Group #: _____

Policyholder Information:

Name: _____ DOB: _____/_____/_____
Policyholder SS#: _____-_____-_____ Phone #: (_____) - _____ - _____
Mailing Address: _____
City: _____ State: _____ ZIP Code: _____

The following individuals are authorized to receive my medical information:

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

****If you DO NOT want your medical information released to another individual, please initial here**: _____.

Please read carefully:

By signing this form, I request and authorize my insurance company to make payments to The Vision Center, P.A. I authorize any medical information necessary to file my claim to be released to my insurance company. If payment is not made by my insurance, I understand that I will be responsible for any outstanding balance on my account. I also understand that any and all fees and co-pays are due at the time of service.

Print Patient Name: _____

Signature: _____ Date: _____/_____/_____