VISIONARY EYECARE

Welcome To Our Office

Patient Information

Name _____Date of Birth _____/_____/_____
First MI Last

Address _____ City _____ State_____ Zip_____

SS# _____-____-_____ Gender Male / Female Ethnicity_____

E-Mail Address _____

Home Phone (____) _____Work Phone (____) _____ext. _____ Cell Phone (____)_____

Above, please circle preferred method of contact

Employer _____ Occupation _____ If Student, Full / Part Time

Marital Status _____Spouse's Name _____ Spouse's Date of Birth _____/_____/_____

Emergency Contact Person _____ Relation _____Phone Number (___) _____

Whom may we thank for referring you to our office? _____

Responsible Party (If different from patient)

Name _____Date of Birth _____/_____/_____

Address _____City _____ State _____Zip _____

SS# _____-____-_____ Gender Male / Female E-Mail Address _____

Home Phone (____) _____Work Phone (___) _____ext. _____ Cell Phone (___) _____

Employer _____ Occupation _____

Vision Insurance Information:

_____ _____
Name of Vision Insurance Insured's First Name MI Insured's Last Name

_____-_____-_____ _____/_____/_____
Insured's SS # Insured's Date of Birth

What is your relationship with the Insured Party? Self Spouse Child Other (circle one)

Medical Insurance Information:

_____ _____
Name of ***Primary*** Medical Insurance Name of ***Secondary*** Medical Insurance

_____ _____/_____/_____
Insured's First Name MI Insured's Last Name Insured's Date of Birth

What is your relationship with the Insured Party? Self Spouse Child Other (circle one)

It is the patient's responsibility to provide all insurance information at the time services are rendered. It is understood that benefits quoted are not a guarantee of payment by an insurance company and final determination of benefits and coverage cannot be made until the claim is processed. Ultimately, it is the responsibility of the patient/guarantor to pay the balance due Visionary Eyecare.

I fully understand the above information and attest that it is true and accurate.

_____ _____
Signature of Patient or Responsible Party **Date**

*** * * SEE OTHER SIDE FOR MEDICAL HISTORY INFORMATION * * ***