PATIENT INFORMATION

Name: _____ Birth Date: ____/____/____
First Middle Last

Address: _____ Home Phone:_____

_____ Cell Phone: _____

Social Security #: _____/____/_____ Email: _____

Marital Status: Married Divorced Widowed Single Separated

Occupation: _____ Employer: _____ Work phone: _____

Name of Medical Doctor: _____ Phone: _____

Other current medical professionals I see: _____

Responsible Party/Parental Access or Legal Guardians:

Name: _____ Relationship to patient: _____
First Middle Last

Address: _____ Phone: _____

_____ Social Security #: _____/___/_____

Employer: _____ Work phone: _____

Please list all legal guardians or parents of minors who legally have access to patient's care and billing information. Include addresses if not the same as above.

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

_____

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

_____

Demographics:

The government requires that we collect certain demographic data on our patients. Sometimes this information is helpful for your care as some eye diseases are more prevalent in certain population demographics. Please circle your responses below.

My preferred language is: English Other: _____

My Race is: White America Indian/Alaska Native Asian Black/African American

Native Hawaiian/Other Pacific Islander Other Race Unknown

Ethnicity: Not Hispanic or Latino Hispanic

Please turn this form over and complete

Insurance Information:
If you need assistance in filing insurance claims for your visits to our office, please fill out the following information and present your cards for us to copy. All prior authorizations and referrals are the patient's/guardian's responsibility. Payments not received from your insurance company within 60 days will be forwarded to you. Payment in full for all services are ultimately your responsibility whether your insurance company chooses to cover the services or pays for only a portion of the fees charged.

Primary Medical Insurance: _____ Policy Holder: _____

Secondary Medical Insurance: _____ Policy Holder: _____

Vision Insurance Company: _____ Policy Holder: _____

Assignment and Release:
I hereby authorize payment directly to Vision Solutions for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctor and/or any provider of supplier of services in this office to release any information required for utilization review and for obtaining payment of benefits. I authorize the use of this signature on all insurance submissions. A copy is as valid as the original. This release is valid until I request in writing this release be terminated.

Release of Information:
To ensure the finest care possible, I hereby authorize Vision Solutions to release information from my records to other medical professionals for the purpose of better informing my other physicians of my current health and visual status. This also allows the doctor's to receive information from other medical professionals to better my care. This release is valid until I request in writing this release be terminated.

Access to Treatment:
The following persons are allowed to seek treatment on behalf of this patient and may discuss the patient's care with the doctor. This release is valid until I request in writing this release be terminated.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Notice of Privacy Practices:
I acknowledge that a copy of Vision Solutions Notice of Privacy Practices was provided to me.

My Signature is for acceptance of all above statements regarding my care:

Signature: _____ Date: _____

Printed name: _____ Relationship: _____

Please turn this form over and complete