VISION SOURCE
PROFESSIONAL EYECARE

Patient Information

Last Name _____ First name_____ MI ____

Address _____
mailing address city state zip code

If mailing address is P.O. Box, what is your physical address?

_____
address city state zip code

Email Address (practice internal usage only) _____

1st (Primary) phone _____ 2nd phone (Cell) _____

Employer Name _____ Occupation _____ Work # _____

Marital status: ☐ Single ☐ Married ☐ Other Sex: ☐ Male ☐ Female

Date of Birth _____ Social Security # _____ Text Reminders OK: Yes ☐ No ☐

Insurance Coverage Information (Please present your insurance card to the front desk)

Vision Insurance Plan _____ Member ID # _____
Name of Insured _____ Insured Date of Birth _____
Group Name _____ Group Number _____

Primary ***Medical*** Insur _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

Secondary ***Medical*** Insur _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

How did you hear about us?
- ❑ Family\ Friends
- ❑ Internet
- ❑ Insurance Listing
- ❑ Doctor\ Referral

Primary Care Doctor: _____

Contact Phone #: _____

Referring Physician: _____

Date of Last Exam: _____

I have read and understood the financial policy. I hereby authorize payment of medical benefits for all covered services to be paid directly to PROFESSIONAL EYE CARE. Every effort will be made to manage my insurance benefits on my behalf, however the primary focus will always be on my physical care. I accept financial responsibility for any service(s) provided to me not covered by my insurance policy and understand that these services are due to be paid on the date that they are rendered or prior to any other services being performed. If the Practice does not participate with my insurance, I accept responsibility for fees that exceed the payment made by my insurance company. I understand that co-payments will be due when I check in for my appointment. All other out of pocket amounts such as coinsurance or deductibles will be due before I leave on my date of service. This practice accepts cash, money orders, VISA, MC, AMEX and Discover.

Privacy Release: I have been given notice of the Privacy Policy of PROFESSIONAL EYE CARE.

_____ _____
Signature (***If patient is a minor, guardian signature is required***) Date