BEL-RED VISION CLINIC

New patient information form

Patient information

Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Social Sec #: _____ Birthdate: _____ Age: _____

Hm phone: _____ Wk phone: _____ Cell: _____

Best number to reach you: Hm Wk Cell Marital Status: Single Married Divorced Widowed Hobbies: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Who may we thank for referring you to us? _____

If you are a student, name of school/college: _____ City: _____

Responsible Party (if different from above)

Name of person responsible for account if not the patient: _____

Address: _____ City, State, Zip: _____

Hm phone: _____ Wk phone: _____ Cell: _____

Employer: _____ Relationship to patient: _____

Insurance Information

Insurance: _____ Group #: _____

Subscriber: _____ ID #: _____

Patient's relationship to subscriber: Self Spouse Child Dependant

Subscriber's employer: _____ Subscribers date of birth: _____

Please read and sign below

We will be happy to bill your insurance for you as a *courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager or any other staff members, not with the doctor.

I acknowledge that I have completed all of the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third party payers and/or other health practitioners if needed. Lastly, I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given.

X _____ Date: _____