Submit Exam/Insurance Form

Patient Status:

PATIENT INFORMATION

First Name:_____Last Name:_____

Birth Month_____ Birth Day_____ Birth Year_____ Age_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Tel:_____ Cell:_____

SS#_____ Gender _____Marital Status_____

Primary Care Physician:_____ Primary Care Physician Phone:_____

Primary Care Physician Email:_____

Referring Physician:_____

Emergency Contact: _____Phone:_____

Whom may we thank for referring you to us?_____

PATIENT EMPLOYMENT INFORMATION

Employer:_____ Work Phone:_____

Work Address:_____

City: _____State:_____ Zip:_____

Email:_____

Relationship to Patient:_____ Patient Status:_____

FINANCIAL RESPONSIBILITY INFORMATION

First Name: _____ Last Name:_____

Birth Month_____ Birth Day_____ Birth Year_____ Age_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone: _____ SS#:_____

Gender: _____ Marital Status_____

Drivers License or State ID: _____ State_____

RESPONSIBLE PERSON EMPLOYMENT INFORMATION

Employer: _____Work Phone:_____

Work Address: _____

City:_____ State:_____ Zip:_____

Email:_____

Do we accept your insurance? Most Likely ...but we still have to process it. Depending on your insurance provider, this process can be time consuming while we try to get the approval necessary for us to proceed with your eyecare plan. Sometimes we find out that your insurance company may have a problem with your coverage that we can correct for you, before you even enter our office! By completing this form on-line, we can take the guess work out of the claim process for you and do all the processing work. We truly want to make your visit to our office a pleasant visit, so our experienced staff will go to work on getting the best coverage possible that you are entitled to by your insurance carrier.

Many times we find situations where your medical insurance and your vision insurance can be applied in conjunction with each other to better cover your needs, so if you have medical insurance please enter your medical insurance carrier information below.

Medical Insurance

Relationship to Patient _____ Patient Status_____

PRIMARY Insurance Person & Info

First Name: _____ Last Name:_____

Birth Month_____ Birth Day_____ Birth Year_____ Age_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone: _____ SS#:_____

Gender: _____

PRIMARY Insurance Company

Insurance Co: _____ Insurance ID #: _____

Insurance Phone:_____

Secondary Medical Insurance

Relationship to Patient _____ Patient Status_____

SECONDARY Insurance Person & Info

First Name: _____ Last Name:_____

Birth Month_____ Birth Day_____ Birth Year_____ Age_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone: _____ SS#:_____

Gender: _____

SECONDARY Insurance Company

Insurance Co: _____ Insurance ID #: _____

Insurance Phone:_____

Vision Insurance

Relationship to Patient _____ Patient Status_____

VISION Insurance Person & Info

First Name: _____ Last Name:_____

Birth Month_____ Birth Day_____ Birth Year_____ Age_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone: _____ SS#:_____

Gender: _____

VISION Insurance Company

Insurance Co: _____ Insurance ID #: _____

Insurance Phone:_____

OTHER INFORMATION - You may elaborate on any information below, and/or in the office