PATIENT INFORMATION

Patient's Name: _____ Social Security#: _____

Home Street Address: _____

City/State/Zip Code: _____

If Child, Parent's Name: _____

Home Phone: _____ Cell: _____ Work: _____

E-MAIL: _____

Sex: Male Female Date of Birth: ____/____/____ Marital Status: _____

Occupation: _____ Employer: _____

Referring Doctor: _____

IN CASE OF AN EMERGENCY, PERSON TO NOTIFY:

Name: _____ *Phone:* _____ *Relationship:* _____

INSURANCE INFORMATION

Insurance Company: _____

Please complete the following if the insured person is NOT the patient

Policy Holder Name: _____ *Date of Birth:* _____

Relationship to the Patient: Parent Spouse

NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT):

_____

Relationship to the Patient: _____ Phone Number: _____

Lifetime Authorization and Assignment of Benefits

I hereby authorize the physicians and staff of Vision One to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to Vision One. I understand that I am financially responsible for all charges arising from services rendered to me by Vision One. I hereby authorize Vision One to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to Vision One. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____