

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/pager _____

Marital Status: Single Married Divorced Widowed E Mail: _____

Occupation: _____ Hobbies: _____

Person to contact in case of emergency: _____ Phone # _____

Whom 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/pager _____

Employer: _____ Relationship to patient: _____

Insurance Information

Insurance: _____ Group # _____

Subscriber: _____ ID # _____

Patient's relationship to subscriber: Self Spouse Child Dependent

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

If we are billing your insurance for you, please read and sign below

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. If insurance is to be billed, I understand that this is a courtesy provided by the eye doctors office, and authorize my insurance company to directly pay the office. I understand that my insurance company may not cover the actual amount for services and materials, and agree to be responsible for payment of any deductible amount, co-insurance or any balance not paid by the insurance company. Lastly, I understand that returns &/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: _____

If we are NOT providers with your insurance company or you are NOT USING INSURANCE, please read and sign

I authorize permission to treat my condition. I am financially responsible for all services at the time they are rendered. As a convenience, I will be provided with a superbill for which I may submit myself to my insurance company. I understand that returns &/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: _____