

INSURANCE INFORMATION

To make your visit progress as smoothly as possible, we ask that you present your MEDICAL and VISION INSURANCE information to our office at least 24 hours prior to your visit. Doing so will not only enable our staff to prepare for your visit, but will help you to come prepared financially if discrepancies in your insurance coverage are found.

Please submit the following information by phone, fax, or return in the mail with your completed patient registration/update form. Please remember to bring your insurance card to your appointment.

PATIENT NAME: _____

PATIENT RELATIONSHIP TO INSURED: Self* Spouse Child Other
**If SELF, please skip "Primary Insured Information" section, and proceed to "Insurance Information."*

PRIMARY INSURED INFORMATION

Insured's Name:		Sex: F M	DOB: / / Age ____
Insured's Address: <i>Check if same as PATIENT'S.</i>			
Street _____ Apt _____		City _____ State _____ Zip _____	
Email Address:		Home Phone: () -	
Employer (if applicable):	Occupation:	Work Phone: () -	
		Cell Phone: () -	
School (if applicable):			Full Time Part Time

INSURANCE INFORMATION

	PLAN NAME	ID NUMBER
MEDICAL INSURANCE		
OPTICAL/VISION PLAN*		

*Vision Benefits of America (VBA) Members: Please contact your insurance company or employer AT LEAST 10 DAYS before your appointment for additional forms necessary to complete your claim. Please bring the completed forms to your appointment.

NOTE: *If you do NOT have a vision plan that will cover your routine visit and the doctor finds NO medical diagnosis, you will be responsible for paying the exam fees as follows:*

New patient	\$125.00	Returning patient	\$115.00
-------------	----------	-------------------	----------