

Welcome to Our Office

PATIENT INFORMATION

Date _____
Last Name _____
First Name _____ Middle Initial _____
SSN# _____
Address _____
City, State, Zip _____
Home Phone () _____
Work Phone () _____
Cell Phone () _____
Date of Birth _____ Sex: M / F
Age _____ Marital Status _____
Referred by _____
Your Occupation _____
Your Employer _____
Employer's Address _____
City, State, Zip _____
Spouse's Name _____
Parent's Name _____
Emergency Contact Name _____
& Phone Number _____
To receive our patient information E-Bulletins, please write
your e-mail address below:
E-mail: _____

INSURANCE INFORMATION

(Please present your insurance card(s)
to receptionist.)

(Please Circle Below if Applicable)

PRIMARY INSURANCE: PPO HMO Medicare

Insurance Company _____

Group Number (if any) _____

Insured's Name _____

Insured's Social Sec. or I.D. # _____

Patient's Relationship to Insured: Self Spouse Child

Insured's Date of Birth (if other than self) _____

Primary Care Physician _____

(Please Circle Below if Applicable)

SECONDARY INSURANCE: PPO HMO Medicare

Insurance Company _____

Group Number (if any) _____

Insured's Name _____

Insured's Social Sec. or I.D. # _____

Patient's Relationship to Insured: Self Spouse Child

Insured's Date of Birth (if other than self) _____

Please Read and Sign Refraction Policy Below:

A "REFRACTION" is a procedure that measures the focusing power of your eyes and allows the physician to determine whether new prescription glasses will help you to see better.

Medicare and most other medical insurance plans **DO NOT** pay for the refraction portion of your eye examination. Some **VISION** plans such as "Vision Service Plan (VSP)" or "Medical Eye Services (MESC)" **DO** cover refractions. Unless you have such a vision plan, you are responsible for the refraction fee, which is due at the time of your visit. If you have any questions about this policy, feel free to ask.

By signing below, I state that I understand and agree that, regardless of my insurance status, I am responsible for payment of refraction fees.

Signed: _____ Date: _____



The Laser Vision Specialists™

www.LASIK121.com