Welcome to VisionCare Specialists

Last Name_____ **First Name**_____ **Date**_____

Address_____**City**_____**State**_____**Zip**_____

Birth Date_____ **Gender: M / F** **Texting Communications OK? Yes / No**

Email: _____ **Cell Phone**_____

Home Phone_____ **Day Phone** _____

Occupation_____ **Employer**_____

Vision Insurance Name_____**Insured ID Number**_____

Employment: Fulltime / Part-time / Self-Employed / Retired / Not Employed

Student: Full-time Part-time / Unknown

Marital Status: Single / Married / Divorced / Widowed

If you are a new patient, how were you referred to us:

Vision Insurance Employer's Vision Program Live in neighborhood Work in neighborhood

Other:_____ Another Patient: (who can we thank?)_____

……

Are you interested in purchasing new glasses today? Yes / Maybe / No

Are you interested in purchasing new contacts today? Yes / Maybe / No

……

I authorize VisionCare Specialists to bill my insurance when possible. I understand that the amounts quoted are not a guarantee of benefits and that I will be financially responsible for charges not covered by my insurance. I authorize the use of my signature on all insurance submissions. I acknowledge that I was offered an opportunity to review or requested and received a copy of our Notice of Privacy Practice for HIPAA.

Patient/Guardian
Signature:_____Date:_____