SHOEMAKER VISION CENTER
1608 PLEASURE HOUSE ROAD SUITE 106
VIRGINIA BEACH, VA 23455

WELCOME TO OUR OFFICE

Thank you for choosing our practice for your eyecare needs. Please complete the following patient information and sign this form for our records. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

PATIENT INFORMATION

Name _____
Title First M.I. Last Suffix Nickname

Address _____
Street Apt/Ste Number City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Where do you prefer to be contacted? _____ Email _____

Birthdate _____ Social Security Number _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Not Employed ☐ Other

Employer _____ Occupation _____

Whom may we thank for referring you to us? _____

Emergency Contact _____ Phone(s) _____

RESPONSIBLE PARTY

Please complete if someone other than the patient is financially responsible for the account.

Name _____
Title First M.I. Last Suffix Nickname

Address _____
Street Apt/Ste Number City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Social Security Number _____

Employer _____ Relationship to Patient _____

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance_____ Identification Number _____

Plan Name _____ Group Number _____

Name of Policy Holder _____ Birthdate _____

Secondary Medical Insurance_____ Identification Number _____

Plan Name _____ Group Number _____

Name of Policy Holder _____ Birthdate _____

VISION INSURANCE INFORMATION

Primary Vision Insurance_____ Identification Number_____

Plan Name _____ Group Number _____

Name of Policy Holder _____ Birthdate _____

Secondary Vision Insurance _____ Identification Number _____

Plan Name _____ Group Number _____

Name of Policy Holder _____ Birthdate _____

I am responsible for all fees at the time of services regardless of insurance coverage, including court costs, reasonable attorney fees and collection agency fees incurred in the collection of the account if it becomes delinquent. The returned check fee is $35.00. Title to any property sold shall be retained by Dr. Garry C. Shoemaker until such property is paid in full. Dr. Garry C. Shoemaker shall have a security interest in all such property.

Signature of Responsible Party_____ Date_____