20/20 Vision Center

Welcome to 20/20 Vision Center! Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Appt Date	Time	Reason

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Age _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Parent or Guardian _____ Family Member Linking All Accounts _____

Emergency Contact _____ Emergency Phone _____

Patient Status ☐ Single ☐ Married ☐ Other ☐ Full Time Student ☐ Part Time Student ☐ Employed

Authorize Emergency Contact to access your Records ? ☐ **Yes** ☐ **No**

How were you referred to our office? (if you are a new patient)

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Location ☐ Other _____ ☐ Doctor (Please Name) _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____ **Patient Relationship to Insured** ☐ Self ☐ Spouse ☐ Child ☐ Other

Office policies, please read:

Additional Appointment Needed: Yes ☐ No ☐

Payment is due at the time of services. If insurance is being used, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. We ask that all materials be paid in full when ordered, and materials will not be ordered until at least a 50% deposit is made. All materials must be paid in full before they will be dispensed. *ALL PRESCRIPTION EYEWEAR is custom made for you specifically, and hence, CANNOT be returned for a refund. All NON-PRESCRIPTION items, such as sunglasses, can only be returned at our discretion, and must be free from ANY defects. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Should it be determined that you have insurance coverage after you have already made payment for such services or materials, please understand, we are under no obligation to bill your insurance company after-the-fact.

By signing below, I acknowledge that I have been given an opportunity to receive a copy of 20/20 Vision Center's Privacy Policies, and that I agree to the above policies.

Signature _____ Date _____