Insurance Information

Patient Information

Patient name (Please print clearly)

Date of Birth

Last name First name Middle name

Address

Sex
M ❑ **F** ❑

Street City State Zip Code

Relationship to Insured

Self ❑ Spouse ❑ Child ❑ Other ❑

Vision Insurance Information

Insurance name Insurance ID# Insurance Group #

Primary Holder's name Primary Holder's SS# Date of Birth

Primary Holder's address

Medical Insurance Information

Insurance name Insurance ID# Insurance Group #

Primary Holder's name Primary Holder's SS# Date of Birth

Primary Holder's address

I understand that occasionally, even though the doctor's office may participate with my insurance, the insurance might for some reason reject the claim. While the doctor's office will do whatever they can to make sure that the insurance reimburses for the claim, I understand that if the insurance rejects the claim I am responsible for the remaining balance.

Signature _____ Date _____