INSIGHT VISION GROUP

☐ **New Patient** ☐ **Established Patient**

____ ____________________
Patient Name DOB

Preferred Pronoun: ☐ She/her ☐ He /him ☐ They/their ☐ Prefer no pronoun ☐ No preference

____ ______________________________
Billing Address City Zip Code

____________________ ____________________ ____________________
Cell Phone Home Phone Work Phone

____
Email Address

May we contact you via email? YES NO

____ ____________________ ____________________
Spouse/Parent/Child Name (anyone that may accompany you) Spouse/Parent/Child Phone Marital Status

____ ____________________ ____________________
Emergency Contact Emergency Contact Phone Employer Name

____ ____________________ ____________________
Preferred Pharmacy Pharmacy Location Pharmacy Phone

Who may we thank for referring you? ____

What is the reason for today's visit? ____

Please list any medications you are currently taking: ____
____

Do you have any allergies to medications or substances? ____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, others pay a percentage of charge, and some do not pay for some charges. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by their insurance.

I directly assign all medical/surgical benefits related to my visits here to Insight Vision Group and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Sign Here:______________________________Date:______________________