INSIGHT VISION GROUP

PLEASE PRINT AND COMPLETE ALL PARTS:

Patient Name: _____ **Today's Date:** _____

Preferred Name: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

E-mail Address: _____ **Social Security #:** _____

Home Phone _____ **Work Phone:** _____ **Cell:** _____

Preferred method of contact: ☐ US Mail ☐ Email ☐ Text ☐ Cell Phone ☐ Home Phone

Employer: _____ **Birth State:** _____ **Mother's Maiden Name:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Parent/Legal Guardian (If patient is under 18):
Name: _____ **Relationship to Patient:** _____ **DOB:** _____
Phone Number: _____ **Address:** _____

Please FULLY fill out this section; include first and last names:
Referred By:

☐ Our Web Site
☐ Insurance
☐ One of Our Patients: _____
☐ Other: _____
☐ Primary Care Physician
☐ Primary Eye Doctor
☐ Specialist Eye Doctor

Primary Care Physician: _____ **Phone:** _____

Primary Eye Doctor: _____ **Phone:** _____

Other Specialist Eye Doctors: _____ **Phone:** _____

INSURANCE (We will need a copy of your insurance card)

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 as valid as the original.

Primary Insurance Company: _____

Primary Insured:
Name: _____ **DOB:** _____ **SS#:** _____

Signature: _____ **Date:** _____