DIMOND VISION CLINIC

****THIS FORM MUST BE COMPLETED ANNUALLY****

PATIENT INFORMATION

Last Name: __________________________ First Name: ________________________MI: _______Preferred Name: ____________

Mailing Address: _____________________________________ City: _____________________State: ________Zip: ____________

Gender: (circle one) Male or Female Date of Birth: _____________________ Preferred Number: _______________________

Home Phone: ___________________ Cell Phone: _____________________ Email Address: _______________________________

Person Responsible for Account: ____Relationship to Patient: __________________

Although we have requested a copy of your insurance card, the information below must be completed. As a courtesy, we will submit billing to your insurance company once, *if* the information below is completed. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and/or your employer.

Unless this information is completed by you ***and*** we have a copy of your insurance card that matches this information we are unable to bill your insurance.

Primary Vision Insurance

Name of Insurance: __________________________________ Member ID# ____

Name of Primary Insured: _____________________________ Relationship to Patient: ___________________________________

Primary Insured's Date of Birth: _________________________ Primary Insured's Employer: ________________________________

Primary Medical Insurance

Name of Insurance: _________________________________ Member ID# ____

Name of Primary Insured: ____________________________ Relationship to Patient: ___________________________________

Primary Insured's Date of Birth: ________________________ Primary Insured's Employer: ________________________________

Secondary Medical Insurance

Name of Insurance: _________________________________ Member ID# ____

Name of Secondary Insured: __________________________ Relationship to Patient: __________________________________

Secondary Insured's Date of Birth: ______________________ Secondary Insured's Employer: ____________________________

Please initial and sign below:

___________ I acknowledge that I have read and signed the Dimond Vision Clinic Statement of Financial Responsibility.

Signature of Patient or Responsible Party: ____Date: __________________