South Holland Vision Center

Welcome To Our Office

Today's Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone

Email Address _____

Social Security Number _____ - _____ - _____ Date of Birth _____ / _____ / _____

Employer (or School) _____ Occupation (or Grade) _____

VISION INSURANCE

Vision Insurance Company: None VSP EyeMed Davis Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

PRIMARY MEDICAL INSURANCE

Medical Insurance Company: None Medicare Medicaid BC/BS Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

ADDITIONAL (SUPPLEMENTAL) MEDICAL INSURANCE

Supplemental Insurance Company: None Medicare Medicaid BC/BS Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare (or other insurance) benefits be made or on my behalf to South Holland Vision Center for any services furnished to me. I authorize any holder of medical information about me to release to the CMS and its agents, or other medical insurance and their agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated on approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I, the patient, am responsible for the deductible, coinsurance, and non-covered services. Coninsurance and the deductible are based upon charge determination of the Medicare carrier (or my other insurance company).

Signature (Insured Patient or Guardian) _____ Date _____