DAVIS VISION CENTER

PATIENT INFORMATION (Please Print)

Name_____ Date_____

Date of Birth_____ Age_____ M/F_____

Address_____
Street City State Zip

Phone: Home (____)_____ Work (____)_____

Cell (____)_____ Email _____

Spouse's Name_____

Parent(s)/ Legal Guardian _____ Phone (____)_____

Referring Physician _____

INSURANCE INFORMATION

☐ **Primary** Medical Insurance _____
Group # _____ ID# _____

Policy holder: ☐ Patient ☐ Other
If Other: Name _____ DOB _____ Relationship_____

☐ **Secondary** Medical Insurance _____
Group # _____ ID# _____

Policy holder: ☐ Patient ☐ Other
If Other: Name _____ DOB _____ Relationship_____

☐ **Workers Compensation** (if job injury)
Employer _____ Occupation _____

EMERGENCY CONTACT

Name _____ Relationship _____
Home phone (____)_____ Work Phone (____)_____

FINANCIAL ASSIGNMENT AND AGREEMENT:

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, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.** I Understand that service charges are assessed at 18% annually on all unpaid balances over 30 days, with a minimum charge of $0.50 per month on any balance past due. I agree to pay all interest charges, collection agency cost/fees, and/or attorney fees and/or court costs if collection of my past due account becomes necessary.

In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I ALSO UNDERSTAND THAT MY EYES MAY BE DILATED during the course of my examination and that as a consequence I may experience transient blurring of vision which may make it difficult for me to drive, read, or carry out normal activities until the affect wears off. Allergic reactions to medications used in this office are very rare. Dark glasses will be available at the end of each visit to provide comfort in bright light.

SIGNED (Patient or parent if minor) _____ **DATE**_____