HOOVER VISION CENTER

PATIENT INFORMATION

(Please Print)

Date: ____/_____/_____ New ________ Update ________

Last name ________________________ First name ___________________ Middle ______________

Preferred name ____________________ Date of Birth ____/_____/_______ Age ____________

Sex M / F Social Security ________ - ______ - ________

Drivers License # _____________________ Marital Status S / M / W / D

Address ____

City ____________________________ State ___________ Zip ___________________

Home Phone __________________ Work Phone _________________ Mobile Phone ______________

Email _____________________________ Occupation __________________________________

Employer ______________________________ Retired ____________ Disabled ___________

If Student: Grade ___________ School _______________________Teacher _____________________

Who referred you to this office ? ____

Please list any family members who are patients of this office.

Name	Relation	Age

Person to notify in case of emergency____

Address____ Phone _______________________

Relationship to patient ____

Insurance Information

Primary *(medical)* ________________________ Policy # ______________________________

Secondary *(medical)* _____________________ Policy #______________________________

Vision Plan______________________________ Policy # _____________________________

Name on card ___________________________ Date of Birth __________________

Social Security # ___________________________

(Please have insurance cards available for receptionist to copy.)

Financial Information

Is patient responsible for bill? Yes / No If not, complete the following information:

Guarantor: Last name ___________________ First name ____________________

Address ____

Home phone ______________________ Work Phone ____________________

Employer _________________________ Relationship _____________________

Please turn this form over and complete side two

Note: Minors must be accompanied by an adult for examination and when picking up materials.

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your copay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. *If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information.* If you have any questions about your insurance or account, please feel free to contact our insurance and billing coordinator.

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Hoover Vision Center for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection. I further agree to waive my rights of exemption as to personal property.

I understand that a finance charge of 1.5% per month shall be added to all balances over 30 days.

I have read the above policies and agree as indicated by my signature.

____ __________________________

Patient or Responsible Party Signature **Date**