

# Welcome to Springboro Vision Center

**PLEASE PRINT**

**Date:** \_\_\_\_\_

Personal Information			
Patient Name <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Birthdate	Age
Last	First	M.I.	Soc. Security #
Address		City	State Zip Code
Home Phone ( )	Business Phone & Ext. ( )	Cell Phone ( )	Email Address
Have we seen other members of your family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Whom?		Whom to contact in case of emergency?(not living w/ you) Name: Phone:	
Name of last Eye Doctor	Date of last eye exam	How were you referred to our office?	

Account Information			
Person Responsible for Payment <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Relationship	Birthdate
Last	First	M.I.	Soc. Sec. #
Address		City	State Zip Code
Home Phone ( )	Business Phone & Ext. ( )	Cell Phone ( )	Email Address Employer

Health Insurance			
Vision Insurance Co.	Policy #	Policy Holders name (Self, Spouse, Parent)	Birthdate
Medical Insurance Co.	Policy #	Medicare #	

PLEASE NOTE: Initial \_\_\_\_\_ Insurance may cover part of your charges, or may be payable directly to you. Please give any forms to the receptionist. We will bill your insurance company; however, if for any reason your insurance does not pay as expected (which may take up to 120 days or more to determine) you will be billed for outstanding balances and/or uncollected copays. Once notified, there will be a 2% service charge for every 30 days there is a balance on your account. There will be a 50% charge added to any outstanding balance turned over to a collection agency.

**Professional Services are payable when rendered.  
Deposit is required on all material orders. Balance in full is due upon delivery.  
Deposit will be forfeit after 180 days.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

### MEDICARE PATIENTS ONLY – AUTHORIZATION TO BILL MEDICARE

I certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit to Medicare for payment to me. I request that payment under the medical insurance program be made either to me or,

_____	_____
Doctor's Name	Patient's Signature
_____	_____
Medicare #	Date Signed