



Welcome to Vacaville Optometric Vision Center

Thank you for choosing our office. In order to serve you properly, we will need the following information. (Please print). All information will be strictly confidential.

1 PATIENT INFORMATION

Date: _____

Patient Name _____

Address _____

City

State

Zip

Phone HOME: _____ WORK: _____ CELL: _____

Sex _____ M _____ F Age _____ Birthdate _____

Who may we thank for referring you? _____

*** * IF PATIENT IS A MINOR, SKIP TO SECTION 2**

Patient's Occupation _____

Employer _____

Employer Address _____

2 BILL PAYER INFORMATION, IF DIFFERENT THAN PATIENT INFORMATION

Name _____

Relationship to patient _____

Address (if different than above) _____

City

State

Zip

Phone HOME: _____ WORK: _____ CELL: _____

Sex _____ M _____ F Age _____ Birthdate _____

Responsible Party's Occupation _____

Employer _____

Employer Address _____

3 VISION INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME _____

Subscriber Name (Covered Employee) _____

Subscriber Birthdate _____

ID Number (this may be the last 4 digits of the subscriber's SS# or a unique ID#) _____

SECONDARY VISION INSURANCE COMPANY NAME _____

Subscriber Name (Covered Employee) _____

Subscriber Birthdate _____

ID Number (this may be the last 4 digits of the subscriber's SS# or a unique ID#) _____

I understand that I am financially responsible for all charges regardless of insurance coverage. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

Method of payment for services/deductibles today: _____ CASH _____ CHECK _____ CREDIT CARD

PLEASE COMPLETE BOTH SIDES