

PAYMENT IS DUE ON THE DAY OF YOUR EYE EXAMINATION

WE ACCEPT:

MASTERCARD, VISA & DISCOVER

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INT _____ MR MRS MISS MS DR

ADDRESS _____ APT# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EXT _____ CELL PHONE _____

GENDER _____ SS# _____ AGE _____ DOB _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PARTY RESPONSIBLE FOR PAYMENT (SKIP IF THE SAME AS ABOVE)

LAST NAME _____ FIRST NAME _____ MIDDLE INT _____ MR MRS MISS MS DR

DOB _____ GENDER _____ SS# _____

ADDRESS _____ APT# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EXT _____ CELL PHONE _____

RESPONSIBLE PARTIES RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE INFORMATION

INSURED'S NAME _____ EMPLOYER _____

INSURANCE COMPANY _____ MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLAN NAME _____ GROUP# _____

WE ARE PARTICIPATING PROVIDERS OF THE FOLLOWING INSURANCE COMPANIES:

VSP, PACIFICARE HMO, PACIFICARE PPO, MEDICARE, MEDICAID, COACCESS, CHP PLUS, BAS, GREAT WEST, AETNA HMO, MOUNTAIN MEDICAL AFFILIATES, 1ST HEALTH, ONE HEALTH PLAN, ROCKY MOUNTAIN UFCW, BLUE CROSS/BLUE SHIELD HMO.

ALL DEDUCTIBLES (CO-PAYS) AND NON-COVERED ITEMS ARE DUE THE DAY OF THE EXAM.

IF YOUR INSURANCE COMPANY IS NOT LISTED ABOVE, WE WILL BE GLAD TO PROVIDE YOU WITH A CLAIM FORM TO SEND TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT TO YOU. HOWEVER, TOTAL PAYMENT IS DUE FOR ALL SERVICES ON THE DAY OF YOUR EXAM. RUSH ORDERS REQUIRE PAYMENT BY CASH OR CREDIT CARD.

SIGNATURE _____ DATE _____