Welcome to Visualeyes Optometry

**** Patient Information****

Name (Last, First, Middle Initial) _____ Sex M / F

How do you prefer to be contacted? □ Home □ Cell □ Work □ Email Preferred Name: _____

Address _____ City _____ State _____ Zip _____

Phone Home ( ) _____ Work ( ) _____ Cell ( ) _____ [ ] OK to text

Email _____ Occupation _____

Birthdate _____ Social Security _____ Driver's License _____

How did you hear about our office? _____

Method of Payment**

Responsible Payor _____ Relationship to Patient _____
Vision Insurance (Circle One) □ 770 □ VSP □ Eyemed □ MES □ Spectera □ Medicare □ Other
Insured's Name (if different than above) _____
Insured's Birthdate _____ SSN _____ Driver's Lic _____
Address_____ Phone _____
Employer _____
Employer's Address and Phone _____

Payment: □ Cash □ Check □ Credit Card

- I understand that I am financially responsible and understand that payment is expected in full at time of the examination.
- Signed: _____ Date: _____

I authorize Visualeyes Optometry/ Dr. Dodge to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependents.
Signed: _____ Date:_____

I authorize payment of medical benefits to Visualeyes Optometry/ Dr. Dodge. I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or coinsurance and that payment for these services is expected on the day the service is rendered.
Signed: _____ Date: _____

Emergency Contact _____ Number _____