

Welcome to Our Office

We appreciate your cooperation in providing us with the following information so we can properly serve your needs.

Minor (under 18) Single Married Widowed

Pt. Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

S.S.# _____ Driver's License: _____ Occupation: _____

Employer Name & Address _____

Name of Spouse: _____ S.S.# _____ Driver's License: _____

Spouse's Employer Name, Address, Phone: _____

If the patient is a minor, the parent bringing the minor in will be responsible for payment:

Father's Name: _____ Address: _____ Phone: _____

Father's S.S.# _____ Father's Driver's License: _____

Employer Name, Address, Phone: _____

Mother's Name: _____ Address: _____ Phone: _____

Mother's S.S.#: _____ Mother's Driver's License: _____

Employer Name, Address, Phone: _____

INSURANCE INFORMATION

We will call to get your coverage and eligibility to the best of our ability. However, insurance companies do not guarantee payment until the claim is filed. You will be responsible for any amounts that the insurance company does not pay. I hereby authorize Hollister Vision Center to furnish the above insurance company(s) all information which said insurance company(s) may request. I permit a copy of this authorization to be used in place of the original. I understand and agree to this statement.

Primary Policy Holder: _____ Birthday: _____

S.S.# _____ Relationship to Patient: _____

VSP (Vision Service Plan) Medicare Supplemental _____

PHA (Pacific Health Alliance) Other _____

MES (Medical Eye Service) No Insurance

Secondary Policy Holder: _____ Birthday: _____

S.S.# _____ Relationship to Patient: _____

VSP (Vision Service Plan) Medicare Supplemental _____

PHA (Pacific Health Alliance) Other _____

MES (Medical Eye Service) No Insurance

I understand and agree that payment is due at the time of the visit.

Patient/Parent Signature: _____ Date: _____