Bulverde Vision Source

Welcome to Bulverde Vision Source. Thank you for choosing us for your eyecare and eyewear needs. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure all the information we have is correct.

Mr. Miss Mrs. Ms. Male Female

Patient First Name _____ Patient MI _____ Patient Last Name _____

Street Address _____ City, State, Zip _____

Social Security Number _____ Date of Birth _____

Home Phone-Include Area Code _____ Cell Phone-Include Area Code _____

Height _____ Weight _____ Ethnicity _____ Race _____

When was your last exam?_____ Email Address:_____

Are you pregnant?_____

Would you like us to "text" you when your order is ready for pickup? Yes No

Primary Insurance Information

Name of Insurance Company _____

M F _____ _____ _____

Insured's First Name Insured's MI Insured's Last Name

Insured's Identification Number _____ Group ID _____ Insured's DOB _____

Patient's Relationship to Insured **Patient's Status** Single Married Other

Self Spouse Child Other FT Student PT Student Employed

Secondary Insurance Information

Name of Insurance Company _____

Male Female _____ _____ _____

Insured's First Name Insured's MI Insured's Last Name

Insured's Identification Number _____ Group ID _____ Insured's DOB _____

Patient's Relationship to Insured Self Spouse Child Other

Please Read:

In order to control cost of billing, we ask that the patient's portion is paid at the time of services rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incured in this office regarless of insurance. Accounts 90 days old are subject to collection fees. Payment from my insurance is to be paid directly to Bulverde Vision source. I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____