

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

M F _____			Name of Insurance Company _____		
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

Male Female _____			Name of Insurance Company _____		
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 incurred in this office regardless 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 _____