

Reed Vision Associates Patient Information Sheets

Age: _____ Today's Date ____/____/____

Name: _____
Last First Initial

Address: _____
Street Alt#

_____ City State Zip Code

Phone # (____) _____ (____) _____
Home/Evening Business/Day

Date of Birth ____/____/____ Social Security # ____ -- ____ -- ____

Email _____ Cell Phone _____

Marital Status Single Married Divorced Widow(er) Sex: Male Female

Employer: _____
Company Name Street City State Zip

Spouse/Parent: _____
Last First Initial ____/____/____
Date of Birth

Relationship to Minor: _____
Signature

Employer Social Security (____) _____
Phone #

(Employer's Address) Street City State Zip

Emergency Contact Person: _____
Name/Relationship Phone #

Primary Care Physician: _____
 (Family Doctor/General Practitioner) Name Phone #

Referred By: _____

INSURANCE INFORMATION

Vision Insurance: _____

Primary Insurance: _____ Subscriber: _____ DOB ____/____/____

Policy # _____ Subscriber's relationship to patient: _____

Secondary Insurance _____ Subscriber: _____ DOB ____/____/____

Policy # _____ Subscriber's relationship to patient _____

I authorize the release of any medical information needed to process all claims and I authorize the release of payment for medical benefits to my physician.

Patient or Parent Signature: _____ Date: ____/____/____

I accept that I am fully responsible for any co-pays, deductibles or items not covered by my insurance. I am also aware that I may be charged a collection fee of \$25.00 if I do not pay Reed Vision for these charges in a timely manner.

Patient or Parent Signature: _____ Date: ____/____/____

Reed Vision Associates Patient Information Sheets

