Patient Name: _____
First M.I. Last

Date of Birth: _____ Social Security #: _____ Race: _____

Gender: _____ Phone: _____ Email Address: _____
Cell Home Work

Mailing Address: _____
Street Name

_____
City State Zip

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Provider & Location: _____

Referring Provider & Location: _____

Preferred Pharmacy: _____ Address: _____

Vision Insurance: _____ Member ID: _____ Group #:_____

Responsible Party: _____ Date of Birth: _____ Last four of SSN: _____

Relationship: Self / Mother / Father / Spouse *SSN is mandatory for VSP insurance!*

Medical Insurance: _____ Member ID: _____ Group #:_____

**PLEASE NOTE: **Your medical insurance is needed in the event that medication or eye drops need to be prescribed to you today or at future appointments****

Financial Responsibilities & Assignment of Insurance Benefits:

I understand that my insurance policy is contracted with I, not with Oak City Vision Center OD PLLC. I understand that I am personally responsible to the provider for all charges for services that are not covered by my insurance. I understand that in the event that Oak City Vision Center OD PLLC is not in-network with my insurance carrier, I will be responsible for 100% of the charges incurred. I understand that not all copays and deductibles are due at the time of service. I understand that Oak City Vision Center OD PLLC reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. In the event medical necessity no longer exists or my payer no loner deems my consult to be covered, I understand I will be responsible for any balance due. I acknowledge receipt and understanding of my patient/Client Bill of Rights and Notice of Privacy Practices. I agree the Oak City Vision OD PLLC may contact me in the future via telephone, email, text messaging, mail or other means of communication regarding my upcoming appointments and/or balances due.

Patient Signature: _____ Date: _____