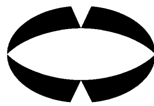

NAPER GROVE VISION CARE

29 South Webster Street
Naperville, IL 60540

5018 Fairview Avenue
Downers Grove, IL 60515

The information contained herein is a part of your medical record and will be kept confidential.
No information will be released without the consent of the patient or the parent's guardian.

PATIENT:

Salutation Mr.___Mrs.____Ms.____Miss.____Dr.____
Last Name ____
First Name ____

Street ____
City _________________ **State** ________ **Zip**__________

Maiden Name _________________**Birth State** ________
Social Security # ____________________________________
Date of Birth ____
Race _________________ **Ethnicity** _________________
Primary Language ________________________________

Nickname ____
Middle Initial ________ **Gender** M ______ F ____
Marital Status **M** **S** **D** **W**
Home Phone _______________________________________
Cell Phone ____
Work Phone _______________________________________
E-Mail____
Please mark * how you preferred to be contacted

Occupation ______________________________________
Employer____

How did you hear about our office?
☐ Insurance Company: _________
☐ Name of Person Referred by: _________________
☐ Internet
☐ Other: _________________

ACCOUNT RESPONSIBLE (Person Responsible for Payment):

Salutation Mr.___Mrs.____Ms.____Miss.____Dr.____
Last Name____
First Name___________________ **Middle Initial**_______

Street ____
City _________________ **State** ________ **Zip** __________
DOB _______________

VISION INSURANCE: Community Vision, BCBS, Cigna, EyeMed, VCP, VSP Other: ____________________

Salutation Mr.___Mrs.____Ms.____Miss.____Dr.____
Last Name____
First Name_________________ **Middle Initial**_______
Street ____
City _________________ **State** ________ **Zip**__________
Hm Phone ____
Cell Phone ____

Insurance ID ________________ **Group** ______________
Date of Birth____________ **Gender** M______ F _______
Social Security ____________________________________
Relation to Insured: *Please Circle One*
Self Spouse Partner Child Student Other

MEDICAL INSURANCE: Aetna, BCBS, CIGNA, Humana, Medicare, UHC Other:_____________________

Salutation Mr.___Mrs.____Ms.____Miss.____Dr.____
Last Name____
First Name_________________ **Middle Initial**________
Street ____
City _________________ **State** ________ **Zip**__________
Phone ______________________**Cell**_________________________

Insurance ID ________________ **Group** ______________
Date of Birth____________ **Gender** M______ F _______
Social Security ____________________________________
Relation to Insured: *Please Circle One*
Self Spouse Partner Child Student Other

Signature on File

- Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductable, coinsurance, or any other balances not paid for by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.
- By signing this statement you agree to be financially responsible for all charges.
- I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

___________________________________ ________________________ ______________
Patient/Responsible Party Signature **Relationship to Patient** **Date**