



# 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 \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Birth State \_\_\_\_\_ Primary Language \_\_\_\_\_

Nickname \_\_\_\_\_

Middle Initial \_\_\_\_\_ Gender M \_\_\_ F \_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

### HOW DO YOU PREFER TO BE NOTIFIED FOR APPOINTMENT CONFIRMATIONS, RECALL, AND PRACTICE UPDATES: (please circle)      EMAIL      OR      TEXT

How did you hear about our office?

Insurance Company: \_\_\_\_\_

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 \_\_\_\_\_

### VISION INSURANCE: Vision Service Plan Vision Max CIGNA BCBS Other: \_\_\_\_\_

Salutation Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss. \_\_\_ Dr. \_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Insurance ID \_\_\_\_\_ Group \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender M \_\_\_ F \_\_\_

Relation to Insured: *Please Circle One*

Self Spouse Partner Child Student Other

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### MEDICAL INSURANCE: BCBS CIGNA Humana Medicare Other: \_\_\_\_\_

Salutation Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss. \_\_\_ Dr. \_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Insurance ID \_\_\_\_\_ Group \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender M \_\_\_ F \_\_\_

Relation to Insured: *Please Circle One*

Self Spouse Partner Child Student Other

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 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 deductible, 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