NAPER GROVE VISION CARE

1331 W 75th St., Ste 403
Naperville, IL 60540

6840 Main St., Ste 250
Downers Grove, IL 60516

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.

PATIENTS INFORMATION:

Salutation Mr.___Mrs.___Ms.___Miss.___Dr.___
Last Name _____
First Name _____
Is this your legal name? Yes No _____

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 W D S
Home Phone _____
Cell Phone _____
Work Phone _____
E-Mail_____

Please mark * how you preferred to be contacted

Occupation _____
Employer_____
Other family members seen here _____

How did you hear about our office?
☐ Referred by: _____
☐ Insurance Company: _____
☐ Internet
☐ Other: _____

WHO IS THE ACCOUNT RESPONSIBLE (Person Responsible for Payment):

Salutation Mr.___Mrs.___Ms.___Miss.___Dr.___
Last Name_____
First Name_____ **Middle Initial**_____

Street _____
City _____ **State** _____ **Zip** _____
DOB _____

WHO CARRIES THE VISION INSURANCE: 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

WHO CARRIES THE 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 _____

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**