DES MOINES VISION CENTER

Welcome to Des Moines Vision Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have on file is current and accurate. If you have any questions, please do not hesitate to ask.

LAST NAME | FIRST NAME | MI | PREFERRED OR NICKNAME

ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | SOCIAL SECURITY NUMBER | M | F | PARENT OR GUARDIAN NAME

CELL PHONE | WORK PHONE | HOME PHONE | E-MAIL ADDRESS

How were you referred to our office?

❒ Insurance Listing ❒ Drive By ❒ Phone Book ❒ Other ❒ Patient (please name) _____

PRIMARY VISION INSURANCE

INSURANCE COMPANY NAME

ADDRESS

CITY, STATE, ZIP

SUBSCRIBER IDENTIFICATION NUMBER

SUBSCRIBER NAME

SUBSCRIBER DOB | GROUP NUMBER

❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

SECONDARY VISION INSURANCE

INSURANCE COMPANY NAME

ADDRESS

CITY, STATE, ZIP

SUBSCRIBER IDENTIFICATION NUMBER

SUBSCRIBER NAME

SUBSCRIBER DOB | GROUP NUMBER

❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

PRIMARY MEDICAL INSURANCE

INSURANCE COMPANY NAME

ADDRESS

CITY, STATE, ZIP

SUBSCRIBER IDENTIFICATION NUMBER

SUBSCRIBER NAME

SUBSCRIBER DOB | GROUP NUMBER

❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

In order to control costs of billing, we require that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts ninety days old are subject to collection fees. There will be a service charge on all returned checks. The patient is responsible for notifying this office of any changes in name, address, phone numbers and insurance information.

I authorize Des Moines Vision Center to use this form for all insurance submissions. I authorize payment from my primary insurance to go directly to Des Moines Vision Center. I understand that Des Moines Vision Center will bill my primary insurance. I understand that it may be my responsibility to bill secondary insurance. I understand that insurance benefits quoted to me are not a guarantee of payment by my insurance and that final determination is not made until the claim is processed. I acknowledge that I have received or been offered a copy of Des Moines Vision Center's Notice of Privacy Practices.

PATIENT (OR GUARDIAN) SIGNATURE _____ DATE _____