Title: ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.

Today's Date: ______________________

First Name: ______________________

Date of Birth: ______________________

Last Name: ______________________

Social Security #: ______________________

Preferred Name: ______________________

Gender: ☐ Female ☐ Male

Address: ______________________

Marital Status: ______________________

City, State & Zip: ______________________

Name of Spouse: (if applicable) ______________________

Preferred Phone: ☐ Home ☐ Cell ☐ Work

Name of Children: (if applicable) ______________________

Home: ______________________

Cell: ______________________

Occupation: ______________________

Work: ______________________

Employer: ______________________

Email: ______________________

How did you hear about our office? ______________________

VISION INSURANCE INFORMATION

Name of Vision Insurance: ______________________

If policy is not under above patient name, please complete the following:

Policy Holder Name: ______________________

Policy Holder Social Security: ______________________

Policy Holder Date of Birth: ______________________

Name of Employer: ______________________

SECONDARY VISION INSURANCE (if applicable)

Name of Vision Insurance: ______________________

Policy Holder Name: ______________________

Policy Holder Social Security: ______________________

Policy Holder Date of Birth: ______________________

Name of Employer: ______________________

MEDICAL INSURANCE INFORMATION

Name of Insurance: ______________________

Policy Holder Name: ______________________

Member ID#: ______________________

Policy Holder Date of Birth: ______________________

Name of Employer: ______________________

AUTHORIZATION & ASSIGNMENT OF BENEFITS:

By signing this form below, I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Iron Horse Optometric Group, unless payment is made in full at time of service. I understand that it may be necessary for me to bill my own insurance company directly.

FINANCIAL RESPONSIBILITY

Your signature on this form acknowledges that you, the patient agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under your benefit plan or we were not made aware of your coverage at the time of services.

Some non-contracted insurance companies have disclaimers stating that they will not guarantee coverage as quoted over the phone at the time of our coverage inquiry.

3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracted provider.

All charges are due and payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies.

______________________ ______________________

Signature **Date**