Patient Information

Please check this information for accuracy. Please make corrections and fill in any missing information.
Thank-you for your cooperation.

Name:
Address
City: **State:** VA **Zip:**
Home Phone:
Work Phone: **Cel Phone:**
E-mail Address:
Birthdate: **Marital Status:** **Sex:**

Social Security No:
Occupation:
Employer/School:

Primary Insurance:
Patient Primary ID:
Primary Subscriber:
Date of Birth:

Guarantor Name:
Guarantor Phone:

Secondary Insurance:
Patient Secondary ID:
Secondary Subscriber:
Date of Birth:

Referred By:

Acknowledgement of Receipt of Privacy Policies

I acknowledge that I received a copy of the Notices of Privacy Practices for this office.

X ______________________________ Date ______________________________

Insurance Authorization

I request that payment for authorized Insurance benefits for any services furnished me, be made on my behalf to: Family Vision Care of Richmond

I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X______________________________ Date ______________________________