

# BETTNER VISION

Thank you for selecting us.  
We strive to provide you with the best possible care. To help us meet your eye care needs, please fill in this form completely. If you have any questions or need assistance, please ask and we will be happy to help you

## **PLEASE FILL IN ALL AREAS**

### ***Patient Information (Confidential)***

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

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

Patient's Birthdate \_\_\_\_\_

Patient's Gender  Male  Female

Employer \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

EMERGENCY Contact \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Patient's SSN \_\_\_\_\_

If minor, parent's name \_\_\_\_\_

Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### ***Responsible Party***

**DO YOU HAVE MEDICAL INSURANCE?**  Yes  No – payment is expected in full today

Name of Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Requires Referral?  Yes  No

Insured's Birthdate \_\_\_\_\_ Home Address (if different from patient) \_\_\_\_\_

Insured's SSN \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home# ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Insured's Employer \_\_\_\_\_

**DO YOU HAVE VISION INSURANCE?**  Yes  No – we will collect your primary insurance copay today.

VSP \_\_\_\_\_ EYEMED \_\_\_\_\_ SPECTERA \_\_\_\_\_ DAVIS \_\_\_\_\_ TRICARE \_\_\_\_\_ OTHER \_\_\_\_\_

**DO YOU HAVE SECONDARY MEDICAL INSURANCE?**  Yes  No

Name of Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Requires Referral?  Yes  No

Insured's Birthdate \_\_\_\_\_ Home Address (if different from patient) \_\_\_\_\_

Insured's SSN \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home# ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Insured's Employer \_\_\_\_\_

### ***Signature***

*I acknowledge that the above information is true. I have read and understand the Financial Policy & Patient agreement on the second page.*

Signed \_\_\_\_\_

Date \_\_\_\_\_