ASHWORTH VISION CLINIC

Welcome to our Practice

Thank you for selecting this office for your eye care needs. Please provide us with the following information so that we can serve you more efficiently.

Patient Information

Name_____
Last Name First Name Middle Initial

Mailing Address_____Home Phone_____

City_____State_____Zip_____

Sex ☁-M ☁-F ☁-Minor ☁-Single ☁-Married ☁-Other
Birthdate_____

Employer_____ Business Phone_____

Occupation_____ How Did You Hear About Us?_____

E-mail_____ Cell Phone_____

If Patient is a Minor

Person Responsible for Account_____
Last Name First Name Middle Initial

Relationship to Patient_____Birthdate_____Soc. Sec. #_____

Address_____Home Phone_____

City_____State_____Zip_____

Responsible Party Employed By_____Business Phone_____

Primary Insurance

Occupation_____

Insured Name_____
Last Name First Name Middle Initial

Relationship to Patient_____Birthdate_____

Insurance Company_____

Subscribers ID#_____Group #_____

Additional Insurance (If Applicable)

Insured N ame_____
Last Name First Name Middle Initial

Relationship to Patient_____Birthdate_____

Insurance Company_____

Subscribers ID#_____Group #_____

I hereby authorized payment of benefits to the above doctor for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorized the above doctor to release any information required to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.
I understand that I am responsible for any and all collection fees and interest charges due to failure to pay.

Signature of Responsible Party_____Date_____