

Welcome to Visualeyes Optometry/ Dr. Dodge's Office.

---

**\*\* Patient Information\*\***

Names: (Last, First, Middle Initial) \_\_\_\_\_ Sex: M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

How do you prefer to be contacted? Home Cell Work Email

Birthdate: \_\_\_\_\_ Social Security \_\_\_\_\_ Driver's License \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

---

**\*\*Method of Payment\*\***

Responsible Payor \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Driver's Lic \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Payment: Cash Check Credit Card

- I understand that I am financially responsible and understand that payment is expected at time of the examination.
- Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Information (Please Present Insurance Card to Optician at Check-in)

770 VSP Eyemed MES Other: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Telephone: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

I authorize Visualeyes Optometry/ Dr. Dodge to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependents.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize payment of medical benefits to Visualeyes Optometry/ Dr. Dodge. I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or coinsurance and that payment for these services is expected on the day the service is rendered.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_