Welcome To Our Office

Welcome to Garland Vision. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. If you have any questions, please do not hesitate to ask.

☐ **Mr.** ☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Male** ☐ **Female**

First Name | **M. Initial** | **Last Name** | **Preferred Name**

Street Address | **City** | **State** | **ZIP**

Social Security Number | **Date of Birth** | **Home Phone** (include area code) | **Work Phone** (include area code)

Email Address | **Spouse or Parent(s) Name** | **Person Responsible for Account**

Emergency Contact* | **Emergency Phone** (include area code)

*** In the event there is an emergency and I cannot make any decisions regarding my healthcare, I authorize the above named person to receive any information regarding my personal health information and to make decisions regarding my care and treatment.**

How were you referred to our office?

☐ **Phone Book** ☐ **School** ☐ **Advertisement** ☐ **Patient** (please name) _____

☐ **Insurance Listing** ☐ **Drive By** ☐ **Other** _____ ☐ **Doctor** (please name) _____

Primary Insurance Information

Primary Insurance Company | **Insurance Company Address** | **City** | **State** | **ZIP**

M ☐ **F** ☐ **Insured's First Name** | **M. Initial** | **Insured's Last Name**

Insured's Identification Number | **Group Number** | **Insured's Date of Birth**

Patient Relationship to Insured

☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Patient Status

☐ **Single** ☐ **Married** ☐ **Other**

☐ **Full Time Student** ☐ **Part Time Student** ☐ **Employed**

Please Read:

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of Insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on returned checks.

I understand that my primary insurance company will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I have received the Notice of Privacy Practices and I have been provided and opportunity to review it.

Signature | **Date**