Welcome to Basin Vision Center: Your Vision Source!

Patient Name_____Nickname_____

Address_____

(Street Address or PO Box) (City) (State) (ZIP Code)

Home Phone_____ Daytime Phone_____

Cell Phone_____ E-Mail Address_____

Gender: Male or Female Date of Birth: _____ Age:_____

Race: White Hispanic American Indian / Alaska Native African American Asian Pacific Islander

(Circle one please)

Patient's Social Security Number:_____ Patient's Marital Status:_____

Patient's Employer: _____ Patient's Occupation:_____PT / FT

Is the Patient new to this Practice? _____ When was the patient's last exam? _____

Do you have medical and/or vision insurance? Yes or No If so, with whom? _____

Patient's Guarantor (If Patient is a Minor)_____

Name of Policy Holder:_____ D.O.B. ___/___/___

Address of Policy Holder_____ Male or Female

(Street Address or PO Box) (City) (State) (ZIP Code)

Policy Holder's Employer_____

Patient's Relationship to Policy Holder:_____

By signing this document you agree to the following provisions as they apply on a continuing basis for all services rendered today or any date hereafter:

- *Payment is expected as services are rendered unless prior financial arrangements have been made.*
- *If Basin Vision Center files an insurance claim(s) for the patient, the patient/guarantor authorizes the release of any medical or other information necessary to process the claim. In addition, the patient/guarantor authorizes payment of medical benefits to the physician or supplier for the services described in the claim(s).*
- *The patient and/or guarantor agree to pay all costs of collection and/or legal fees for the collection of payments.*

Signature:_____ Date:_____