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:____________________________ Email:____

I authorize □ I do not authorize □ the use of text and email communication.

Gender: Male or Female Date of Birth:___________________________________ Age:________

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

Patient's SSN:__________________________ Patient's Martial Status:_________________________

Patient's Employer:___________________________ Occupation:__________________________ PT / FT

Is the Patient new to this Practice? YES NO When was the patient's last exam?__________________

Do you have medical insurance? YES NO If so, with who?_____________________________________

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 Holer's Employer:____

Patients 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/guarantor authorizes the release of any medical or other information necessary to process 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:_________________________