Verona Vision Care

Welcome!

320 South Main Street
Verona, WI 53593
www.veronavisioncare.com

Patient Information

Date_____

Patient's Name _____ Preferred Name_____

Address _____

City_____ State_____Zip_____

Preferred Phone: ☐ Home ☐ Cell _____ Work _____

Email Address _____ Date of Birth ____/_____/_____

Occupation_____ Name of Employer_____

Race: ☐ American Indian ☐ Asian ☐ Black or African American
☐ Pacific Islander ☐ Caucasian ☐ Other

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Please list any members of your household who come to our office_____

_____

How did you hear about our office? _____

Referred by _____ May we send a thank you note? ☐Y ☐ N

Insurance Information

Do you have vision care insurance? ☐ Y ☐ N Name_____

Primary Insured Name_____DOB_____I.D. Number_____

Do you have health insurance? ☐ Y ☐ N Name_____

Please note**: Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, payment is expected at the time of services and we will be happy to provide you with a receipt to submit to your insurance company for reimbursement. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims. Please give any forms to the receptionist. If you are using insurance: I authorize the release of any medical or other information necessary to process this claim. **I accept responsibility for payment of products and services.

HIPAA Privacy Act

I have been offered a copy of the HIPAA privacy act for Verona Vision Care.

_____ _____ _____

Print Name Signature of Patient (or Guardian, if under 18) Date

NOTICE: There is a contact lens evaluation fee in addition to the exam fee.