Welcome To Our Office!

REUNIONOPTICAL

Please complete the following confidential information. If you would like assistance completing this form, our staff will be happy to help you!

○ Mr. ○ Ms.
○ Mrs. ○ Dr.
○ Miss ○ _____

First Name legal/ (preference) | M.I. | Last Name

Date Of Birth

Mailing Address

City: | State: | Zip Code:

Social Security #, Or Last 4 Of SSN

Email Address

Phone Numbers

Home Phone

Cell Phone

Vision Insurance Company:

Medical Insurance Company:

Name: | Phone:

Insurance ID #:

Group #:

Insurance Company Address:

City: | State: | Zip Code:

Financially Responsible Party/ Parent Information:

Name: | Phone #:

Address:

City: | State: | Zip Code:

Date Of Birth:

Social Security #, Or Last 4 Of SSN:

Payment is expected at the time services are rendered including non-covered portions of insurance

The insurance plan billed for services will be determined based on the diagnosis code assignged by the doctor following the examination. This process ensures compliance with insurance billing guidelines and accurately reflects the medical necessity of the the services rendered. Initial: _____

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. We do not guarantee the accuracy of benefit information given to us by the insurance companies!!! Please understand that you are financially responsible for your account, not your insurance company.

Signed: _____ Date: _____

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to the undersigned physician or supplier for services rendered. Signed: _____

Our office does utilize electronic communications via text & email for purposes of appointment reminders, annual exam notices, and occasional billing. We do not share your information with any third parties for marketing purposes. Data rates may apply. Opt In: ☐ Opt Out: ☐