Access Optical Medical / Insurance In-Take

Date of Service: _____/_____/2016

Patient Name (Last)_____ (First) _____

Patient Date of Birth (mm)_____(dd)_____(yy)_____ Sex: Male ___ Female ___

Insured's Name (Last)_____ (First) _____ (Middle Initial) _____

Patient Name (Last)_____ (First) _____

Patient Address (#, Street)_____ (City) _____(State)_____(Zip)_____

Patient Telephone (Home)_____ (Work) _____(Cell)_____

Patient Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Insured's Address (same as above) (____)

(#, Street)_____ (City) _____(State)_____(Zip)_____

Patient Status: Single ___ Married ___ Other ___ Employed ___ Full Time Student ___ Part Time Student ___

Insured's Date of Birth (mm)_____(dd)_____(yy)_____ Sex: Male ___Female ___

Insurance Plan Name or Program Name _____

Insured's Identification # _____

Secondary Insurance Information

Other Insured's Name (Last)_____ (First) _____ (Middle Initial) _____

Other Insured's Policy or Group Number: _____ Other Insured's ID # Number:_____

Other Insured's Date of Birth (mm)_____(dd)_____(yy)_____

Insurance Plan Name or Program Name _____

Is Patient's Condition Related : Employment Yes ___ No ___ Auto Accident Yes ___ No ___ Other Accident Yes ___ No ___

Insurance Assignment and Release **Signature on File Release**

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to the offices of Dr. Richard Bohn, Optometrist, all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The office of Dr. Richard Bohn, Optometrist, may use my healthcare information and may disclose such information to the respective Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature or Legal Guardian X_____ DATE _____/_____/2016

Please Print Name _____ Relationship to Patient

_____

*******SIGNATURE ON FILE WILL ALSO SERVE AS AUTHORIZATION TELEPHONE ORDER CREDIT CARD PURCHASES ******