WELCOME TO VALLEY VISION CARE

PATIENT INFORMATION

Name:____ Date:_____________________

Address:_____________________________City:______________________State:_____ZIP________

Date of birth:______________Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced/ Separated ☐ idowed

Home phone: ____________________________cell phone#_____________________________

email address_____________________________

Patient's Occupation, if Employed:______________________ Business phone: ____________________

Name and Address of Employer:____

Patient's school, if student:____ Grade:____________

This is a professional office that abides by the rules and regulations of the HIPAA privacy policy. A copy of this policy is available upon your request. <u>The following information is required.</u>

Social Security number #:____________________ Driver License#_____________________________
if patient is a minor parent/guardian SS# if patient is a minor parent/guardian #

How did you hear about our office?
☐ Friend / relative (please name) __________________________ ☐ Insurance company
☐ Postcard from our office ☐ Radio ☐ Yellow pages ☐ Referred by your doctor

In case of emergency, whom should we contact?________________________Phone:_________________

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Insurance Information

Do you have VISION insurance ? ☐ YES ☐ NO

IF YES, insurance company name:____

Do you have MEDICAL/HEALTH insurance? ☐ YES ☐ NO

IF YES, insurance company name:____

<u>Please present your insurance card to the receptionist</u>.

<u>The below information needs to be completed:</u>

Insurance Card holder name ___________________________________ Date of Birth:______________

Relationship to patient:______________ Social Security number:______________________

Address: (☐ Check if same
as patient) ____

Insureds Employer: ___________________________________Business phone:___________________

Business address:____

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ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Daniel Kohansby and/or Valley Vision Care for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on behalf of my dependents.I f my insurance company requires a referral ,I am responsible for obtaining one.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. For school children, a report of the exam findings may be sent to the child's school nurse unless you notify us otherwise.

SIGNATURE OF RESPONSIBLE PARTY:____________________________________DATE____________

(Signature of Responsible Parent or guardian if Patient is under age 18)