VISION SOURCE™

Dr. David S. Davis
4840 E. Bonanza Rd. Suite 6
Las Vegas, NV 89110
(702) 385-7331

Patient Name:_____Birth Date: _____Gender: ☐Male ☐Female

Social Security Number: _____ ❑Single ❑Married ❑Widowed ❑Divorced

Home Phone: _____ Cell Phone: _____ Text: ☐Yes ☐No

Address: _____*Apt*_____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____ Referred By: _____

Responsible Party (if different from above): _____ *Relation:* _____

Social Security Number: _____ *Birth Date:* _____

Contact Number: _____

When was your last eye examination? _____ or First Exam

Have you ever worn glasses before? ☐ YES ☐ NO

You would be interested in? (Check all that apply)

☐ Glasses ☐ Contacts (Previous Wearer) ☐ Computer Wear
☐ Sunwear ☐ Contacts (New Wearer) ☐ Lasik

Diabetic: ☐Yes ☐No If yes, last blood sugar reading: _____ Date:_____

Primary Medical Physician: _____

NEW: Required in compliance with Healthcare Regulations

Race/Ethnicity: ☐Asian ☐American Indian or Alaska Native ☐Black or African American
☐White ☐Native Hawaiian or Pacific Islander ☐Unknown
☐Hispanic or Latino ☐Other _____

Preferred Language: ☐ English ☐ Other _____

Please fill out both sides

Vision Plan Information ☐ **Not billing any vision insurance**

Primary Vision Insurance: _____

Insured Name:_____ Insured Birth Date: _____

Relation to Patient: _____ Social Security Number: _____

Secondary Vision Insurance: _____

Insured Name:_____ Insured Birth Date: _____

Relation to Patient: _____ Social Security Number: _____

Health Insurance Information *(Many eye problems are covered by your health insurance.)*

Primary Medical Insurance: _____

Insured Name:_____ Insured Birth Date: _____

Secondary Medical Insurance: _____

Insured Name:_____ Insured Birth Date: _____

Please read and sign below:

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services. Accounts 90 days old or older are subject to any collection fees that may be incurred. There will be a service charge on returned checks.

I hereby authorize payment directly to Dr. David S. Davis O.D., for any services rendered to me by Dr. David S. Davis O.D., or any of his authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:1) acquired in the course of my examination or treatment and 2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. David S. Davis O.D., or any of his authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

X

_____ _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE DATE