SOUTHLAKE VISION ASSOCIATES

Welcome To Our Office

Please raise any questions about our fees and policies, insurance coverage, or any other concerns to the technician prior to seeing the doctor.

Patient Information:

Title: Mr. Mrs. Ms. Dr.	Nickname:	
Last Name:		
First Name:		MI:
Address:		
City: State:		Zip:
H Phone #:		
Daytime #:		
Date of Birth: Age:		Sex: M F
Employer:	Occupation: :	
E-mail address:		

Guardian Information (if patient is under 18):

Title: Mr. Mrs. Ms. Dr.		
Last Name:		
First Name:		MI:
Address:		
City: State:		Zip:
H phone #:		
Daytime #:		
Date of Birth: Age:		Sex: M F
Employer:	Occupation: :	

How were you referred to our office? ☐ Yellow pages ☐ Internet ☐ Lenscrafters ☐ Driving by
☐ Friend or family member ______________________________
Name of Person we should thank

Insurance Information:

Vision Insurance:	Health Insurance:
Group Number:	Group Number:
SSN:	SSN:
Primary Insured:	Primary Insured:
Insured's SSN:	Insured's SSN:
Insured's DOB:	Insured's DOB:

☐ All insurance coverage must be pre-approved prior to your examination. **If we are unable to verify coverage, all charges must be paid in full when services are rendered**. If you are not eligible for insurance benefits, or are eligible for less than full coverage, your signature below indicates that you agree to be financially responsible for any unpaid balance. Professional fees for services are non-refundable.

☐ Your signature below indicates that you agree to forward within 14 days any monies paid to you by your insurance company that is owed to Southlake Vision Associates

______________________________ ______________________________ ______________

Signature of Patient or Responsible Party   Printed Name   Date