

VISIONLOFT Patient History Questionnaire

Patient Name _____ Age _____
Last First MI

Mailing Address _____ City _____ St _____ Zip _____

Home Phone # _____ Daytime/Work Phone # _____

Cell Phone # _____ Patient Date of Birth ____ / ____ / ____

Email Address: _____ @ _____ .Com
(Vision Loft Use Only for appointment confirmations, office related email)

Employer _____ Circle: Full Time Part Time FT Student PT Student

Occupation _____ Marital Status (Circle): Married Single Widowed Domestic Partner

In Case of Emergency Contact _____ Phone _____

How did you find out about us? Circle: Sign on Building Insurance Who Can We Thank?: _____

PLEASE READ THE FOLLOWING AND INITIAL:

_____ Please provide us with your current Vision and Medical insurance information. As a courtesy we are happy to file your claim. If you are unable to provide us with the necessary information prior to your appointment you will need to pay at the time of service and file for reimbursement with your insurance company. Unfortunately the verification of benefits does not guarantee payment and you will be responsible for charges that are not covered by your insurance.

VISION INSURANCE

Name of Insurance: _____ Policyholder's Name _____

Policyholder's Employer _____ Policyholder's Date of Birth ____ / ____ / ____

Policyholder's Address: _____ City _____ ST _____ Zip _____

ID Number _____ Group# _____

Policyholder's S.S. # _____ - _____ - _____

MEDICAL INSURANCE

Name of Insurance: _____ Policyholder's Name _____

Policyholder's Employer _____ Policyholder's Date of Birth ____ / ____ / ____

Policyholder's Address: _____ City _____ ST _____ Zip _____

ID Number _____ Group# _____

Policyholder's S.S. # _____ - _____ - _____

Acknowledgement of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our privacy officer.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient/Guardian Signature _____ Date _____