Alameda Vision Center

Responsible Party Information:

Patient Name: _____ **Date of Birth:** _____ **Sex: M F**
(First) (M.I.) (Last)

Parent or Guardian: _____ **SSN:** _____
(First) (M.I.) (Last)

Home Address: _____

City:_____ **State:** _____ **Zip:** _____

Phone (H): _____ **(C):** _____ **(W):** _____

Employer: _____ **Occupation:** _____

Emergency Contact Name: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Email: _____

Pharmacy: _____ **Phone #:** _____

Insurance Information:

Primary Insurance: _____ **Policy #:** _____

Policy Holder's Date of Birth: _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's SSN:** _____

Policy Holder's Phone #: _____

Policy Holder's Address: _____

Secondary Insurance: _____ **Policy #:** _____

Policy Holder's Date of Birth: _____ **Group #:** _____

Policy Holder's Name: _____ **Policy Holder's SSN:** _____

Policy Holder's Phone #: _____

Policy Holder's Address: _____

Contact Lens Evaluation and Payment Policy:

Contact lens evaluation and prescription are an **additional service** and are not part of a routine healthy eye exam. Most vision insurance companies **do not cover** the associated fee of this additional testing.

Payment is due at time of service. A 50% deposit is required **before** materials are ordered. The balance is due in full at time of delivery. Third party payment (insurance) will be filed on your behalf; however payment must be received before dispensing. Any insurance benefit in excess of the account balance will be immediately refunded to the patient after we receive payment from the insurance company.
To my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes to my medical status.

Signature: _____ **Date:** _____

Relationship to patient: _____ **Parent/Guardian Date of Birth:** _____