JACKSONVILLE VISION CENTER O.D., PLLC

**PATIENT CONTACT INFORMATION:**

Name: _____

Birthdate: _____ SS# _____-____-_____

Address: _____

City:_____ Zip:_____

Phone Numbers

(check box of preferred number to be reached at)

□ Home:(_____) _____-_____

□ Cell: (_____) _____-_____

□ Work: (_____) _____-_____

Email Address:_____

*(for patients under 18 years of age)*

**RESPONSIBLE PARTY :**

Name:_____

Relationship to Patient:_____

May we send appointment reminders to your email address?

Yes No (circle one)

May we send appointment reminders to in the form of text messages to your cell phone?

Yes No (circle one)

**INSURANCE INFORMATION:**

**Primary Medical Insurance**: _____ Name of Policy Holder:_____

Subcriber ID # _____ Policy Holder's SS# _____

Pt's relationship to subscriber: _____ Policy Holder's DOB: _____

****For **Tricare** Members: please check box that applies to your Tricare Insurance:*

☐*Prime Active Duty* ☐*Prime Retired* ☐*Standard Active Duty* ☐*Standard Retired*

**Secondary Medical Insurance**:_____ Name of Policy Holder:_____

Subcriber ID # _____ Policy Holder's SS# _____

Pt's relationship to subscriber: _____ Policy Holder's DOB: _____

**Vision Plan (if applicable)**: _____ Name of Policy Holder:_____

Subcriber ID # _____ Policy Holder's SS#: _____

Pt's relationship to subscriber: _____ Policy Holder's DOB: _____

**CONSENTS:** (Need signature of parent or guardian if patient is under 18 years of age)

1) I have been provided with "Notice of Privacy Practices" from *Jacksonville Vision Center, O.D., pllc.*

2) I understand that I am responsible for charges not covered or reimbursed by the above agents, I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required).

3) I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to *Jacksonville Vision Center, O.D., pllc.*

*Patient Signature (or responsible party):* _____ *Date:*_____