TRI VALLEY OPTOMETRY

Welcome to Tri Valley Optometry!

To make sure we have accurate information, please fill out the following:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________________

PATIENT INFORMATION (Please Print)

(Dr., Mr., Mrs., Ms., Miss) Last________________________ First________________________________
Address____
City____ State__________ Zip ______________________
Cell_________________________ Home___________________ Other___________________________
Work________________________ E-Mail____
Birthday__________________________ Social Security #_______________________________________
Marital Status: Single Married Widowed Divorced
Patient's Employer____________________________ Occupation________________________________
Name of Person Responsible for payment____
Relationship to Patient ________________________ Phone Number______________________________
Bill Payer's Employer _____________________________ Occupation______________________________
Emergency Contact Name_____________________________ Phone Number__________________

Tri Valley Optometry's office policy is for you, the patient, to pay in full when services are rendered. Please realize that professional services and materials are charged to you, the patient, and not the insurance company. As a courtesy to our patients, we will bill VSP, Medicare, and any other insurance company that we are contracted with. Ultimately, you are responsible for payment of services and material fees.

In order to process your claim efficiently, please provide the following information:

Primary Vision Insurance_____________________________ Phone _____________________________
Address_____________________________ City_________________ State______ Zip_______________
Subscriber's Name___________________________________ SS#_________________________________

Secondary Vision Insurance____________________________ Phone______________________________
Address_____________________________ City_______________ State_______ Zip________________
Subscriber's Name ___________________________________ SS#_________________________________

Major Medical Insurance_______________________________Phone_____________________________
Address_______________________________ City______________ State________ Zip ________________
Subscriber's Name _____________________________________ SS# ________________________________

Please circle the method of payment for today's services: CASH CHECK CREDIT

SIGNATURE____ DATE______________________