

# ALL FAMILY

*vision care*

Welcome to All Family Vision Care! Thank you for taking the time to fill out our patient demographic form.  
1597 SW 53<sup>rd</sup> St. Corvallis, OR 97333 Ph: (541) 757-8844 Fax: (541) 754-9810 www.allfamilyvisioncare.com

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male  Female

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Best Contact Phone: Cell  Home  Work  \_\_\_\_\_ Alternate Number: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Primary Vision Insurance

Company: \_\_\_\_\_ Employer \_\_\_\_\_ ID# \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_/\_\_\_\_/\_\_\_\_

Permanent Address/Insured's Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Secondary Vision Insurance Company: \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Subscriber: \_\_\_\_\_ Date of Birth of Secondary Insured: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Who may we thank for referring you to All Family Vision Care? \_\_\_\_\_

## Thank you for your visit today!

I understand that you will bill my insurance as a courtesy to me. However, I also understand that I am ultimately responsible for the total amount due, should my insurance company decline to pay or if I do not have insurance. I understand that payment of at least half of my portion of the total bill (including any co-pays) is expected at the time services are rendered and before my glasses or my contacts will be ordered. I authorize my insurance company to make payment directly to the provider. If my insurance company pays me instead of the provider, when the provider should have received the payment, I agree to inform the provider and pay the amount owed in full. I am aware that there is a **\$25.00 returned check fee** policy in effect in this office. Should my account have to be turned over to collections, I agree to be responsible for any extra fees that this office might incur due to such a situation. My signature on this form is acceptance of these terms and may also be used as the signature on file for insurance purposes. If I have any questions regarding any of this information I am free to inquire before my exam and before I place an order. Signature is required before an exam takes place and before an order is placed.

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_