Family Vision Welcomes You!

Anderson **Williamston** **Clemson**

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to fill out this demographics form so we can update our system with correct information.

First Name _____ M.I. _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State / Zip Code _____

Social Security Number _____ Date of Birth _____ Home Phone (___)_____ Cell Number (___)_____

E-Mail Address _____ Person Responsible for Account _____

Patient's Status:
( ) Single ( ) Married ( ) Employed ( ) Full Time Student ( ) Retired ( ) Other

How were you referred to our office?
( ) Family or Friend ( ) Ins. Co. ( ) Job Referral ( ) Patient Referral ( ) Internet ( ) Other

INSURANCE INFORMATION:

Name of Medical Primary _____ Name of Vision Insurance _____ Supplementary Ins. _____

Insured's Identification # _____ Insured's Identification # _____ Identification # _____

Group Number _____ Insured's SS # _____ Group Number _____

Relationship _____ Relationship _____

PLEASE READ:
I assign all of my medical benefits to Family Vision and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I understand that if some fees are not paid by my insurance that I am responsible and will be billed for them. Accounts 90 days old are subject to collections and there will be a service charge for all bounced checks . All co-payments, deductibles, and charges for non-covered services are due at the time of service.

Signature _____ Date _____

I permit Family Vision to communicate and remind me about my health related issues and appointments by text and/or email.

Signature _____ Date _____