DuPont Family Vision Clinic, PLLC

Welcome to DuPont Family Vision Clinic, PLLC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ : Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Home Phone - Include Area Code ______ Day Phone ______

Email Address ______ Guardian ______ , Person Responsible for Account ______

Emergency Contact ______ Emergency Phone ______

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? ______

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ______ City ______ State Zip ______

M ☐ F ☐ Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ______ City ______ State Zip ______

M ☐ F ☐ Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

We ask that the patient's portion is paid at the time services are rendered. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge of $30 on all returned checks.

We will attempt to be as accurate as possible estimating patient responsibility. 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. Payment from my insurance is to be paid directly to DuPont Family Vision Clinic, PLLC. I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility.

A copy of DuPont Family Vision Clinic Notice of Privacy Practices has been made available to me. I understand my rights regarding my medical records.

Signature ______ Date ______