

GRANGE VISION

Stephen M Waclawski, O.D.

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www.grangevision.com

Please fill out front and back of form

DATE: _____

PATIENT: _____
LAST NAME FIRST NAME INITIAL

STREET ADDRESS: _____

CITY: _____ STATE: WI ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ SEX: M F BIRTHDATE: _____

EMAIL ADDRESS: _____

PRIMARY PHYSICIAN: _____

STREET ADDRESS: _____ State: WI Zip: _____

EMPLOYER: _____ OCCUPATION: _____

F/T P/T RETIRED STUDENT-SCHOOL: _____

How did you learn about our practice? _____

INSURANCE INFORMATION:

SS#: _____

VISION INSURANCE: _____ POLICY#: _____

MEDICAL INSURANCE: _____ POLICY #: _____

RESPONSIBLE PARTY: *(WHO CARRIES THE INSURANCE)* _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: *(if different then above)* _____

CITY: _____ STATE: WI ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

BIRTHDATE: _____ SS#: _____

Used for insurance purposes

WORK PHONE: _____

Payment is requested when services are rendered.

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the doctor named above, and I am financially responsible for non-covered charges. I also authorize the release of any information necessary to process this claim.

SIGNATURE: _____ DATE: _____

We appreciate the opportunity to serve you!