



**WELCOME TO OUR OFFICE**

**PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Preferred Salutation: MR. MRS. MS. MISS DR. Other: \_\_\_\_\_ Gender: M F  
Date of Birth: \_\_\_\_\_ Name of Spouse/Parent: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Email address: \_\_\_\_\_ May we contact you by email? \_\_\_\_\_  
Who may we thank for referring you to us? \_\_\_\_\_  
Name of person responsible for payment: \_\_\_\_\_  
Primary Insurance Company: \_\_\_\_\_ Insured: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_ Insured: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_

The Wise Vision Group will utilize the information provided here to contact you.

**CONSENT FOR THE RELEASE OF HEALTH & BILLING INFORMATION**

I give my permission for the following persons to speak with Ronald E. Wise, M.D. and associates regarding my Information: (CIRCLE HEALTH BILLING OR BOTH)

- |          |                     |                |      |
|----------|---------------------|----------------|------|
| 1) _____ | Relationship: _____ | HEALTH BILLING | BOTH |
| 2) _____ | Relationship: _____ | HEALTH BILLING | BOTH |
| 3) _____ | Relationship: _____ | HEALTH BILLING | BOTH |
| 4) _____ | Relationship: _____ | HEALTH BILLING | BOTH |

**PLEASE READ THE FOLLOWING AND SIGN BELOW**

I authorize insurance payment of medical benefits to Ronald E. Wise, M.D., P.C. for all services. I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical or other information to other health care providers when requested. I also request payment of government benefits to Ronald E. Wise, M.D., P.C. on my behalf.

**Patients will be responsible for all charges not covered by their insurance company.**

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

**\*\*This form is valid for 3 years from date signed or until updated prior to expiration date.**

\_\_\_\_\_  
Expiration Date