



WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW

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

Patient's Name: _____ Date: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Work Phone: (____) _____
 Email address: _____ Alternate 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: _____
 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: _____

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: **(PLEASE 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. **The Wise Vision Group is unable to guarantee any insurance coverage and or benefits. 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