



WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW

Patient's Name: _____ Date: _____

Home Address: _____ Nick Name _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Please contact us immediately upon a change in any demographic information to allow excellent communication with our office.

Preferred Salutation: MR. MRS. MS. MISS DR. Other: _____ Gender: M F

Date of Birth: _____ Name of Spouse/Parent: _____

Social Security #: _____ Drivers License #: _____

Occupation: _____ Employer: _____

Employer Address: _____ City State Zip: _____

Email address: _____ May we contact you by email? _____

Emergency Contact Name: _____ Contact Phone: (____) _____

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: _____ **Other Physician** _____

Telephone/City: _____ Telephone/City: _____

In an effort to ensure coordination of care we will be sending a summary of your examination to your Primary Care Physician for certain medical diagnoses.

******The Wise Vision Group will utilize information provided above 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

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 (see our Financial Policy for details).

Payment Methods: Cash, Personal Check, Money Order, MasterCard™, Visa™, and Care Credit

Patient or Responsible Party Signature

Date

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

Expiration Date