



Welcome!

320 South Main Street
Verona, WI 53593
www.veronavisioncare.com

Patient Information

Date _____

Patient's Name _____ Preferred Name _____

Address _____

City _____ State _____ Zip _____

Preferred Phone: Home Cell _____ Work _____

Email Address _____ Date of Birth ____/____/____

Occupation _____ Name of Employer _____

Race: American Indian Asian Black or African American

Pacific Islander Caucasian Other

Ethnicity: Hispanic Not Hispanic

Please list any members of your household who come to our office _____

How did you hear about our office? _____

Referred by _____ May we send a thank you note? Y N

Insurance Information

Do you have vision care insurance? Y N Name _____

Primary Insured Name _____ DOB _____ I.D. Number _____

Do you have health insurance? Y N Name _____

Please note: Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, payment is expected at the time of services and we will be happy to provide you with a receipt to submit to your insurance company for reimbursement. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims. Please give any forms to the receptionist. If you are using insurance: I authorize the release of any medical or other information necessary to process this claim. **I accept responsibility for payment of products and services.**

HIPAA Privacy Act

I have been offered a copy of the HIPAA privacy act for Verona Vision Care.

Print Name _____

Signature of Patient (or Guardian, if under 18) _____

Date _____

NOTICE: There is a contact lens evaluation fee in addition to the exam fee.