ROCKRIMMON VISION SOURCE

Welcome To Our Office!!

Full Legal Name:	
I prefer to be called:	**Sex:** F ☐ M ☐
Street Address:	
City: State:	Zip:
Date of Birth:	Social Security #:
Home Phone:	Daytime Phone:
Cell Phone:	Email Address:
Preferred Language:	
Ethnicity:	Communication Preference: Telephone ☐ Email ☐ Text ☐
Employer Name: Employer Address:	
Please list other family members in your household:	

Guarantor And Insurance Information

(Please list the person who is responsible for your bill)

Guarantor's Name:	Guarantor Home Phone:
Guarantor's Address:	Guarantor's Employer:
Guarantor SS#:	Patient's Relationship to Guarantor: (circle one)
Guarantor Date of Birth:	Self Spouse Child Other
Insurance Company:	
Who may we thank for referring you to our office? How did you hear about us?:	
Please list someone outside your household to contact in case of an emergency: Name: Phone:	

Explanation of Practice Financial Policy: Payment is expected at the time of service. Insurance billing and insurance payment is based upon individual insurance guidelines. I hereby authorize payment of vision, medical and surgical benefits directly to Rockrimmon Vision Source. I have read and understand that all vision, medical and surgical charges incurred by myself, or my dependents for services rendered by Rockrimmon Vision Source are my financial responsibility. All court, attorney, or other fees necessary to collect this account are payable by me.

Signed: _____ **Date:** _____