



**IRONTON
VISION
CENTER, INC.**

Patient Information Form

Date _____ Email Address _____

Name _____ Cell _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Referred by _____

SSN _____ Driver's License No. _____

Occupation _____ Employer _____

Work Phone _____ Address _____

Who is financially responsible for accounts? _____

I will be paying today by: Cash ___ Check ___ Credit Card ___

Medical Insurance Company _____ Number _____

Policy Number _____

Co-Insurance _____ Number _____

Vision Insurance _____ Number _____

Spouse's Name _____ Employer _____

Nearest Relative not living with you _____ Phone _____

Nearest Friend not living with you _____ Phone _____

Physician _____ Phone _____

Dentist _____ Phone _____

Landlord _____ Phone _____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services and/or materials rendered. I understand that the Ironton Vision Center, Inc., Doctors Steven C. Milleson or Nick Weber will bill my insurance company, but since it is my insurance, I agree to pay the same account in full within 30 days from my date of service regardless of the status of my claim. I understand that the IVC and Dr. Milleson or Dr. Weber are billing my insurance company as a courtesy. I have completed the above and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature _____ Date _____