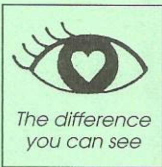

IRONTON VISION CENTER, INC.

Patient Information Form

Date____________________ Email Address__________________________ State of Birth ______________

Name______________________________________ Mother's Maiden Name _________________________

Phone_________________________ Cell_____________________ Cell Carrier ________________________

Street Address ____

City____ State_______ Zip _________________________

Date of Birth______________________ Sex__________ Referred by _______________________________

SSN__________________________________ Driver's License No. ________________________________

Occupation______________________________ Employer ______________________________________

Work Phone____________________________ Race_______________ Ethnicity __________________

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, Patrick E. 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 ____________________

Form H