Welcome To The Office of Drs. Waren and Fiegel

Please help us provide the best care for you and allow us to file the appropriate insurance for your visit by completing the following information.

Patient's Name:_____ SSN:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip:_____

Email Address:_____ Business Name:_____

Home Phone:_____ Business Phone:_____

Job Title:_____ Date of Last Exam:_____

Optometrist's Name:_____ Family Doctor:_____

Birth Date:_____ Age_____ Gender:_____ Cell Phone:_____

Sports/ Hobbies: _____

Who may we thank for referring you? (How did you hear about us?) _____

INSURANCE-PLEASE PRESENT YOUR CARDS TO THE RECEPTIONIST

Vision Insurance:	ID#	Vision Insurance Member Name:
Relationship to Patient:	Member's Date of Birth:	Member's SSN#
Other Vision Insurance Plans:	ID#	Other Vision Insurance Member Name:
Relationship to Patient:	Member's Date of Birth:	SSN#
Primary Medical Insurance:	ID#	Primary Member Name:
Relationship to Patient:	Member's Date of Birth:	Primary Insurance Member SSN#
Secondary Medical Insurance:	ID#	Secondary Member Name:
Relationship to Patient:	Member's Date of Birth:	Secondary Insurance Member SSN#

I Understand that by signing this consent form I am allowing my medical information to be released to my insurance company for such purposes as claims payment, provider review and quality assessment. I may revoke this consent in writing at any time. I understand that any claim not paid by my insurance company will be my responsibility.

_____ _____

Signature of Patient or Responsibility Party Date

_____

Relationship to Patient