VMR INSTITUTE, A MEDICAL CORPORATION

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss   Gender: ◯ M ◯ F   Age ____   Preferred Language ____________

Last ____________ First ____________ Middle ____________

Date of Birth (MM/DD/YYYY) ____________   SSN ____________   ◯ Married ◯ Divorced ◯ Single ◯ Widow

RACE ____________   ETHNICITY ____________

Patient Contact Information:

Address ____________   Home Phone ____________

City ____________ State ____ Zip Code ____________   Cell Phone ____________

E-mail ____________

Employer ____________   Phone Number ____________   Occupation ____________

Spouse Name ____________   SSN ____________   Spouse Date of Birth (MM/DD/YYYY) ____________

Emergency Contact Information:

Name ____________   Phone ____________

Referral Information:

Referred By ____________   Phone ____________

Current Eye care Provider ____________   Phone ____________

Primary Physician ____________   Phone ____________

Primary Pharmacy ____________   Phone ____________

Is your condition/injury work related: ◯ Yes ◯ No   If yes, please describe ____________

Insurance Information:

Insurance Company ____________   Employer ____________

Policy Holder's Name ____________   Date of Birth (MM/DD/YYYY) ____________

Group # ____________   Member ID # ____________

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Domestic Partner

Type of Plan: ◯ PPO ◯ EPO ◯ POS ◯ HMO/IPA ◯ MEDICARE/ CALOPTIMA ◯ SUPPLEMENTAL ◯ WORKERS' COMP.

Additional or Secondary Insurance:

Insurance Company ____________   Employer ____________

Policy Holder's Name ____________   Date of Birth (MM/DD/YYYY) ____________

Group # ____________   Member ID # ____________

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Domestic Partner

Type of Plan: ◯ PPO ◯ EPO ◯ POS ◯ HMO/IPA ◯ MEDICARE/ CALOPTIMA ◯ SUPPLEMENTAL ◯ WORKERS' COMP.

PLEASE READ THE FOLLOWING AND SIGN BELOW

I, the undersigned, realize that all medical and surgical charges incurred are my financial responsibility and hereby authorize VMR Institute to bill my insurance on my behalf. I hereby authorize the release of medical information to my health plan or its intermediaries any information needed for this or related claim. A photocopy of this document shall be as valid as the original.

I HAVE READ THE ABOVE AND AGREE TO ABIDE BY ITS TERMS AND FURTHER ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLYTO VMR INSTITUTE.

PATIENT'S SIGNATURE ____________   **PRINT NAME** ____________

PARENT/GUARDIAN'S SIGNATURE ____________   **DATE** ____________