Professional Visioncare Associates

Morton Greenspoon, O.D. Richard L. Silver, O.D. Stacey Sumner, O.D. Nancy McBride, O.D.

Name: _____ Marital Status Sex
Last First Middle S M P D W M F

Address: _____
Number Street City Zip

Social Security #_____ Driver's License #_____

Birth Date _____ Age_____ Occupation _____

Home Phone _____ Work Phone _____

Employer _____ Work Address _____

E-mail address _____ Cell Phone _____

Spouse _____ Spouse Work # _____

Spouse Employer _____

Responsible Party for Payment _____

General Family Doctor_____ Date Last Seen _____

Who May We Thank for Referring You? _____

Preferred Method of Payment (Please Check One):

☐ Cash ☐ Check ☐ Visa/MC ☐ AMEX

Are you a member of any of the following?

Medicare ☐ Medical Eye Services ☐ Cigna ☐

Blueshield/United Healthcare ☐ Vision Service Plan ☐

*Please note that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or other balance not paid by your insurance.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to: Morton K. Greenspoon, O.D.
Richard L. Silver, O.D., and Stacey Sumner, O.D., Nancy McBride, O.D

I understand I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed _____ Date _____