INSURANCE INFORMATION

Primary Insured ***if not yourself*** _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Social Security # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Person Employed by _____ Occupation _____

Text AUTHORIZATIONS

I, the undersigned, have insurance with _____
Name of Insurance Company
and assign directly to Dr. Breazeal all medical benefits, if any, otherwise payable to me for services rendered. I understand that during my exam, medical issues may be found that require medical testing and that my medical insurance may be billed. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X _____ X _____
Signature or Insured/Guardian Date

Office Use Only			
Vision		**Medical**	
Name of Rep:	Date:	Name of Rep:	Date:
Exam-	copay	Office Visit-	copay
Frame-$			
SV-$	**Eligibility**		VF (92083)
BI-$	Exam	Deductible-$	Photos (92250)
TRI-$	YES NO	Met-$	OCT (92133)
Contacts-$	Hardware		OCT (92134)
Options-$	YES NO		Topog (92025)