VMR INSTITUTE, A MEDICAL CORPORATION

Submit Form | Print Form

◯ 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 ____

Cell Phone ____

City ____ State ____ Zip Code ____ 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 ____