# VMR INSTITUTE, A MEDICAL CORPORATION

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◯ 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 ____