Dr. David S. Davis
4840 E. Bonanza Rd. Suite 6
Las Vegas, NV 89110
(702) 385-7331

Patient Name:________________________ Birth Date: _______________ Gender: ☐Male ☐Female

Social Security Number: _______________________ ❑Single ❑Married ❑Widowed ❑Divorced

Home Phone: ______________________ Cell Phone: _______________ Text: ☐Yes ☐No

Address: ____ *Apt*_______________

City: ____________________________ State: _____________ Zip Code: __________________

E-Mail Address: ___________________________ Referred By: ___________________________

Responsible Party (if different from above): ___________________ *Relation:* _______________

Social Security Number: _____________________ *Birth Date:* ____________________

Contact Number: ________________________

When was your last eye examination? _________________ or First Exam

Have you ever worn glasses before? ☐ YES ☐ NO

You would be interested in? (Check all that apply)

☐ Glasses ☐ Contacts (Previous Wearer) ☐ Computer Wear
☐ Sunwear ☐ Contacts (New Wearer) ☐ Lasik

Diabetic: ☐Yes ☐No If yes, last blood sugar reading: __________ Date:_______________

Primary Medical Physician: ____________________________________

NEW: Required in compliance with Healthcare Regulations

Race/Ethnicity: ☐Asian ☐American Indian or Alaska Native ☐Black or African American
☐White ☐Native Hawaiian or Pacific Islander ☐Unknown
☐Hispanic or Latino ☐Other ___________________

Preferred Language: ☐ English ☐ Other _________________

Please fill out both sides

Vision Plan Information ☐ **Not billing any vision insurance**

Primary Vision Insurance: ______________________________

Insured Name:____ Insured Birth Date: _______________

Relation to Patient: _________________________ Social Security Number: ______________________

Secondary Vision Insurance: ___________________________

Insured Name:____ Insured Birth Date: _______________

Relation to Patient: _________________________ Social Security Number: ______________________

Health Insurance Information *(Many eye problems are covered by your health insurance.)*

Primary Medical Insurance: ___________________________

Insured Name:____ Insured Birth Date: _______________

Secondary Medical Insurance: ___________________________

Insured Name:____ Insured Birth Date: _______________

Please read and sign below:

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services. Accounts 90 days old or older are subject to any collection fees that may be incurred. There will be a service charge on returned checks.

I hereby authorize payment directly to Dr. David S. Davis O.D., for any services rendered to me by Dr. David S. Davis O.D., or any of his authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:1) acquired in the course of my examination or treatment and 2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. David S. Davis O.D., or any of his authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

X

____ ____________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE DATE