

WyoVision Associates, Inc. Welcome Back To Our Office

Welcome to WyoVision Associates, Inc.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms.

Male Female

First Name	MI	Last Name	Preferred Name
Street Address		City	State Zip
Social Security Number	Date of Birth	Home Phone - Include Area Code	Day Phone
Email Address	Guardian	Person Responsible for Account	

Emergency Contact _____ Emergency Phone _____

How were you referred to our office?

Who were you referred by?

- Phone Book School Advertisement Patient
 Insurance Listing Drive by Other Doctor

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company		City	State Zip
M <input type="checkbox"/> F <input type="checkbox"/>	Insured's First Name	MI	Insured's Last Name
Insured's Identification Number	Group Number	Insured's Date of Birth	
Patient Relationship to Insured		Patient Status	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/> Employed	

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company		City	State Zip
M <input type="checkbox"/> F <input type="checkbox"/>	Insured's First Name	MI	Insured's Last Name
Insured's Identification Number	Group Number	Insured's Date of Birth	
Patient Relationship to Insured			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that _____ will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. 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.

Signature _____

Date _____

WyoVision Associates, Inc.
PATIENT HISTORY AND INFORMATION

Name _____

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Native Hawaiian Or Other Pacific Islande
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African America	<input type="checkbox"/> Declined To Specify
<input type="checkbox"/> Hispanic Or Latino	

Other Race _____

Ethnicity

Hispanic Or Latino Not Hispanic Or Latino Declined To

Preferred Language

English Chinese Dutch; Flemish French German Hindi

Height ft in cm/m ft in cm m Weight lbs kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician _____ City _____ State _____ Zip _____ Phone _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician _____ City _____ State _____ Zip _____ Phone _____

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Pharmacy: _____