

## Welcome to Wineinger Vision Associates!

In order to bill your insurance company please complete all of the following information:

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last \_\_\_\_\_

Nickname \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Parents' Names, if child \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Home telephone (\_\_\_\_\_) \_\_\_\_\_ Work telephone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Cell phone (\_\_\_\_\_) \_\_\_\_\_ Emergency contact name & phone # \_\_\_\_\_

1. If you do not have Vision Service Plan (VSP), please present your vision insurance card to the receptionist when returning this completed form.

2. If you have health insurance, please present your health insurance card.

3. Do you have secondary vision or health insurance?  Yes  No If yes, please present this insurance card also.

4. Are you a college student?  No  Yes, full-time  Yes, part-time

5. What is your marital status?  Single  Married  Divorced  Legally Separated  Widowed

If your insurance is through **your** employer, please proceed to question 8. If not, please answer all questions.

6. What is your relationship to the insured member?  Spouse  Child  Grandchild  Other \_\_\_\_\_

7. What is the insured member's: Full Name \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

8. Member's employment status is:  Employed Full-Time  Employed Part-Time  Retired  Self-Employed  
 Active Military Duty  Other \_\_\_\_\_

*Unless we are a participating provider for your insurance plan,  
payment is expected at the time of your exam.*

**Verifying eligibility does not guarantee payment from your insurance company.**

*Payment in full is required for all materials (glasses and contact lenses)  
before they are ordered.*

**I understand that I am responsible for paying my co-payment and any non-covered services and material fees today. If for any reason my insurance company denies payment, the total fee for services and materials is my responsibility.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(parent or guardian, if minor)

*Please present this completed form and your insurance card(s) to the receptionist. Thank you!*