VALLEY VISION CENTER

Travis J. Shelton, O.D.
106 S Main St ~ PO Box 429
Lyman, WY 82937

Patient Name:_____ Date of Birth: _____/_____/_____ Male / Female

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home PH:_____ Cell:_____ Work:_____

Social Security #:_____ Marital Status:_____ Race:_____

Email:_____ Employer:_____

Primary Care Physician:_____Phone:_____

Does a report need to be sent: Yes / No If yes, reason:_____

Responsible Party: _____ Date of Birth: _____/_____/____ Male / Female

Address if different than pts:_____ City:_____ State:_____ Zip:_____

Responsible Party's Employer: _____

INSURANCE INFORMATION

Primary Ins:_____ Phone: _____

Billing Address: _____ City:_____ State:_____ Zip:_____

Policy ID#_____ Group #_____

Policy Holder:_____ Date of Birth: _____/_____/_____

Secondary Ins:_____Phone: _____

Billing Address: _____ City:_____ State: _____ Zip:_____

Policy ID#_____ Group #_____

Policy Holder:_____ Date of Birth: _____/_____/_____

In consideration of professional services rendered to the above patient, I/we agree to pay your customary charge for these services in full at the time of the service I/we authorized this office to receive assignment of insurance payments. If customary charges are more than the benefits allowed under my/our insurance plan I/we will pay the difference. I/we further understand all past due accounts may be subject to a $10.00 service charge. **initials: _____**

If my insurance company denies any or all charges, I/we agree to be personally and fully responsible for payments. **initials: _____**

I/we hereby authorize this office to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. **initials: _____**

_____ _____ ____/____/____

Signature of Responsible Party | Print Name and relationship | Date