COLLEGEOPTICAL

BOULDER COLORADO

Welcome To Our Office!

Please complete the following confidential information. If you would like assistance completing this form, our staff will be happy to help you!

○ Mr. ○ Ms.
○ Mrs. ○ Dr.
○ Miss

First Name | M.I. | Last Name

Mailing Address

Date Of Birth

City: | State: | Zip Code:

Social Security #

Email Address

Phone Numbers

Day Phone | Home/Cell Phone

Vision Insurance Company:

Medical Insurance Company:

Name: | Phone:

Insurance ID #:

Group #:

Insurance Company Address:

City: | State: | Zip Code:

Financially Responsible Party/ Parent Information:

Name: | Phone #:

Address:

City: | State: | Zip Code:

Date Of Birth:

Social Security #, Or Last 4 Of SSN:

Payment is expected at the time services are rendered including non-covered portions of insurance

How did you select our office?

○ Insurance ○ Yelp ○ Family has been in
○ Google ○ Referred By: _____
○ Facebook ○ Other: _____

Please Note:

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. We do not guarantee the accuracy of benefit information given to us by the insurance companies!!! Please understand that you are financially responsible for your account, not your insurance company. Signed: _____ Date: _____

I authorize the release of any medical information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signed: _____

I auhorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Signed: _____