TODAY'S DATE: ______________

Scott Bailey, O.D.

5919 Harbour Park Drive • Midlothian, Virginia 23112

Phone: 804-739-8646 • Fax: 804-739-9651

Age ________

Appointment Date ______________________________

Patient's Name (please print) ______________________________

If a Child, Parent's Name ______________________________

Street Address ______________________________

City ______________________ State ________ Zip Code ____________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

E-mail Address ______________________________

Birth Date ______________ M or F ________ SSN ______________

Employer ______________________ Occupation ______________________

Spouse's Employer ______________________ Work Phone ______________

Health Insurance Carrier ______________________ Policy # ____________

Vision Insurance Carrier ______________________ Policy # ____________

Medicare / Medicaid ______________________ Policy # ____________

How did you find out about our office? ______________________________

Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees that you have paid to the optometrist for services rendered. Having insurance is not a substitute for or guarantee of payment. We will assist you in receiving as much reimbursement as possible. However, it is your responsibility to pay any balance not paid by your insurance company. My signature below indicates that I have been offered a privacy policy by Dr. Scott Bailey, OD, PC. It also indicates that I grant permission for Dr. Scott Bailey to bill my insurance company on my behalf. I have read the above responsibility statement and agree that I am financially responsible for all charges not covered by my insurance company.

Signature ______________________________ Date ____________

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