AURORA **EYECARE**

HEALTH · VISION · STYLE

WELCOME BACK TO OUR OFFICE!

Patient Information

Last Name______________________________ **First Name**______________________________

Street Address____

City____ **State**_______ **Zip**_______________

Preferred Phone Number______________________________________ this is a ___Cell ___Land Line

E-Mail Address____

Has your *MEDICAL* insurance changed since your last visit? ____**Yes** ____**No**

If yes, what is your new *MEDICAL* insurance? ______________________________________

Insurance Name

Medical insurance will be filed for all non-routine exam visits

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Identification Number

Change In Insurance Information

- Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, **not** Aurora Eye Care.
- If your insurance company has not reimbursed our office in full within **90 days**, you are responsible for providing payment in full to Aurora Eye Care.

Signature

I have read and understand the Consent Form and consent to the use and disclosure of my health information for the purpose of treatment, payment and health care operations.

____ ____________________

Patient Signature (Guardian signature if patient is a minor) Date

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