ALLIEDVISION
SERVICES

Patient Information

Dr. ____ Mr. ____ Mrs. ____ Ms. ____ Miss ____ Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Name _____ Gender M / F Date of Birth_____

Address _____ City _____ State _____ Zip Code _____

Social Security # (Last four digits) _____ E-Mail _____

Telephone (H) _____ (W) _____ (C) _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

Preferred Language (circle) English / Spanish / French / Japanese / Declined to Specify

Race (circle) American Indian or Alaskan Native / Asian / Black or African American / Hispanic
Native Hawaiian or Other Pacific Islander / White / Declined to Specify

Ethnicity (circle) Hispanic or Latino / Not Hispanic or Latino / Native Hawaiian or Other Pacific Islander / Declined to Specify

Communication Preference (circle) E-mail / Postal / Telephone

Responsible Party

Name of Person Responsible for the Account_____ Date of Birth _____

Address _____ Home Phone _____

Social Security # (Last four digits) _____ Relation to Patient _____ Currently a patient in our office? Yes ____ No ____

Employer _____ E-Mail _____

Primary Insurance Information

Insurance Company _____ ID# _____ Group # _____

Name of Insured: _____ Relation to Insured: _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

Additional Insurance Information

Insurance Company _____ ID# _____ Group # _____

Name of Insured: _____ Relation to Insured: _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

The preceding information is true to the best of my knowledge and I request any applicable payments of insurance be made on my behalf to Allied Vision Services for any services rendered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or benefits for related services. **I understand that I am responsible for any referrals needed for services rendered here (if in a managed care insurance program), and for any fees not covered by my insurance company owed to Allied Vision Services.**

Patient / Parent Signature _____ Date _____

Acknowledgement of Receipt

I acknowledge that I have received a copy of Allied Vision Services of Plainsboro's Notice of Privacy Practices.

Patient/Parent Signature _____ Date _____