Emily Skibo, O.D.
4200 Ilberry Road - Mt. Vernon, IL 62864
(618) 242-6338 (Phone) - (618) 242-0465 (Fax)

PATIENT REGISTRATION INFORMATION

Welcome to our office! Thank you for choosing our office for your eye care. Please take the time to complete this form accurately and completely. It helps us to do the best job possible for you. This information is held in complete confidence, as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Preferred salutation:
Dr. Mr. Mrs. Miss Ms. Reverend Other:__________ SS#________________________

Last | First | Preferred Name | Date of Birth | Age

Residence Address | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

Residence Phone | Business Phone | Extension | Employer | Occupation

Responsible Party (if diff. from above) | Address | City | State | Zip Code

Referred by | Date of Last Eye Exam | Previous Eye Doctor (City & State)

INSURANCE INFORMATION

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason. We also require your PRIMARY CARE PHYSICIAN'S NAME & PHONE NUMBER.

MEDICAL INSURANCE CO. | Policy Holder | SS# | Primary Care Doctor | Phone

VISION INSURANCE COMPANY | Policy Holder | SS# | Policy # | Group #

FINANCIAL POLICY INFORMATION

Please indicate method of payment: [ ] Cash/Check [ ] Visa/MasterCard

All Co-Payments and individual portions of your balance are due at the time of service. If you participate in any of the following insurance plane, you are responsible for these amounts at time of service. Payment in full for all services and materials is due at time of service.
[ ] VSP [ ] Eyemed [ ] Medicare

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage.

Signature | Date | Relationship to Patient