Discover Vision Centers
PO Box 804904
Kansas City, MO. 64180-4904
816.478.1230

PATIENT INFORMATION

NAME (Last,First,MI)	MRN	SSN	BIRTHDATE	SEX

ADDRESS	CITY,ST,ZIP	2NDARY ADDRESS (if applicable)

HOME PHONE	DAY PHONE	EMAIL	CITY,ST,ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER?	VETERAN?	2NDARY HOME PHONE
	☐ F/T ☐ P/T			

EMPLOYER INFORMATION

PRIMARY EMPLOYER	2NDARY EMPLOYER (if applicable)

ADDRESS	CITY,ST,ZIP	CITY,ST,ZIP

WORK PHONE	MAY WE CONTACT YOU AT WORK?	2NDARY WORK PHONE
	☐ Yes ☐ No ☐ Emergency Only	

PRIMARY INSURANCE

INSURANCE COMPANY	POLICY #

ADDRESS	CITY,ST,ZIP	GROUP#

NAME OF INSURED (PRIMARY HOLDER)	RELATIONSHIP TO PATIENT	COPAY AMOUNT	DEDUCTIBLE
		$	$

CUSTOMER SERVICE PHONE#		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

INSURANCE COMPANY	POLICY #

ADDRESS	CITY,ST,ZIP	GROUP#

NAME OF INSURED (PRIMARY HOLDER)	RELATIONSHIP TO PATIENT	COPAY AMOUNT	DEDUCTIBLE
		$	$

CUSTOMER SERVICE PHONE#		EFFECTIVE DATE	EXPIRATION DATE

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance benefits be paid directly to the physician. I understand I am responsible for all co-pays, deductibles and co-insurance amounts.

PRIVACY INFORMATION

By my signature I verify that I have received or was offered a copy of Discover Vision's Notice of Privacy Practices. Only those whom I list in the space provided are authorized to discuss my medical care or billing with a Discover Vision representative.

SIGNATURE OF PATIENT (or guardian if patient is a minor) **DATE**