TODAY'S DATE: _____

Lauren Johnson, 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 Visionary Optometry, PLLC. It also indicates that I grant permission for Dr. Lauren Johnson 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 _____