Insurance Information

Primary Insurance

CO_____ID#_____GROUP#_____

Secondary Insurance

CO_____ID#_____GROUP#_____

Vision Insurance

CO_____ID#_____GROUP#_____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DAVIDORF EYE GROUP. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SEVICES. I UNDERSTAND THAT THE INITIAL INSURANCE INFORMATION GIVEN BY ME WILL BE BILLED AND DAVIDORF EYE GROUP WILL NOT REBILL OTHER INSURANCE AFTER MY DATE OF SERVICE.

SIGNED: _____DATE:_____