VSP INSURANCE FORM

EMPLOYEE INFORMATION

Primary Insured Last Name _____ **First Name** _____ **M.I.** _____

Primary Insured Birth date ___/_____/_____ **M** ❑ **F** ❑

Address _____ **City** _____

State _____ **ZIP** _____

Phone (_____**)**_____ **Social Security No.** _____ - _____ - _____

Relationship to Patient (circle one): ❑**Self** ❑**Spouse** ❑**Child** ❑**Other**

Signature _____ **Date:** _____

PATIENT INFORMATION

Patient's Last Name _____ **First Name** _____**M.I.** ____

Patient's Birth date ___/_____/_____ **M** ❑ **F** ❑

❑ **Address Same as Employees**

Address _____ **City** _____

State _____ **ZIP**_____

Phone Number (_____**)**_____

FOR OFFICE USE ONLY

Authorization Number _____ **Copay $**_____