



Please complete all sections of this form to the best of your ability

Name _____ Date of Birth _____

Address _____ SSN _____

City _____ St _____ Zip _____

Sex (circle one) M F Marital Status (circle one) S M D W

Home _____ Work _____ Cell _____

Please check the box(es) at the numbers above permitting us to contact you for appointment reminders or any other correspondence.

How did you hear about us? (circle one) Family/Friend Website Facebook Advertisement

Email address _____ Employer _____

Race _____ Ethnicity (circle one) Hispanic/Latino Not Hispanic/Latino

We are required by law to request Race/Ethnicity information from you. If you prefer not to complete the Race and/or Ethnicity portion of the form, please write refused in the space above.

Emergency Contact _____ Phone _____

Preferred Pharmacy _____ Location _____

Referring Physician _____ Primary Care Physician _____

Friends/Relatives we may release your medical information to:

Name _____ Relationship _____

Insurance Information

Policy Holder Name (example: Joe Smith) _____

Relationship to patient _____ Date of Birth _____

- I authorize the release of any medical information necessary to process this claim. I also request payment of benefits to the provider on all claims that he may accept assignment on. I understand that I am responsible for all non-covered services and any balance that may not be covered by insurance. _____ (Initial)
- I authorize the release of any information in my chart to any medical practitioner, insurance company, doctor, hospital, pharmacy, optical dispensary or any other medical institution to which I may be referred to assist with my medical care. _____ (Initial)
- I understand that an annual refraction fee of \$35.00 will not be covered by most health insurance policies and that I am responsible for payment of this fee plus my co-pay (if applicable) at the time of service. A refraction is a vision test that is a necessary part of a complete eye exam. _____ (Initial)
- I acknowledge the Notice of Privacy Practices is kept on file in the practice and is available for my review and can be explained to me if I have any questions. _____ (Initial)

Sign _____ Date _____