PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

How did you hear about our practice? Yellow Pages____ Newspaper____ Insurance List____ Website_____
Dr.'s Office (Name)_____ Other Patient (Name) _____ Other_____

Name_____
Mailing Address_____
City_____ State _____ Zip _____
Phone Hm_____ Wk_____Cell_____
Email Address_____ Preference: email mail telephone
Last 4 Digits of Soc. Sec. #_____ Sex: M F Race: White Hispanic Other _____
Age_____ Birthdate __/__/__ Marital Status S M D W Language: English Other_____
Employer or Retired from _____
Employer Address_____ Occupation_____
Spouse's Name _____Spouse's Employer _____
Have we seen any of your family members? Names

Party Responsible for Charges Not Paid by Insurance

☐ Same as above
Name _____ Relationship to Patient _____
Address _____
City _____ State_____ Zip _____
Last 4 Digits of Soc. Sec. #_____Phone Hm _____ Wk _____
Employed or Retired from _____
Employer Address

Insurance Information

Vision Insurance _____ # _____Group _____
Member _____ Date of Birth _____/_____/_____
2nd Vision Insurance _____#_____ Group _____
Member _____ Date of Birth _____/_____/_____
Major Medical Insurance _____# _____Group _____
Member Date of Birth / /

Release of Benefits/Medical Information and Lifetime Medicare Authorization

I authorize my insurance benefits to be paid directly to the Optical Shop of WA, Inc. I am financially responsible for any balance due. I also authorize The Optical Shop of WA, Inc. or my insurance company to release any information required for this claim. I understand that the Optical Shop of WA, Inc is billing my insurance as a courtesy and any balance remaining (even if misquoted by the insurance company to the Optical Shop of WA, Inc.) IS MY FINANCIAL RESPONSIBILITY. Fees are due at the time of my appointment unless other arrangements have been made in advance. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits or benefits for related services.

I understand that The Optical Shop of WA, Inc. keeps a record of all services provided to me and that I am entitled to complete access to these records. I may also ask The Optical Shop of WA, Inc. to correct these records. My records will not be disclosed to others unless directed by me, or unless the law authorizes The Optical Shop of WA, Inc. to do so.

Signature _____ **Date** _____

Patient, Parent (if a minor), or Guardian.

THANK YOU! WE WELCOME YOU AS A NEW PATIENT TO OUR PRACTICE!

Updated (Initial/Date) _____ _____ _____ _____ _____