

Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Referred By \_\_\_\_\_

List all Medications \_\_\_\_\_

Type of Vision Insurance \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Parent/Guardian Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Children's Names at Home \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All fees are due and payable at the time of service, unless prior arrangements have been made.**

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_