Welcome to Family Optometric Vision Care

LAST NAME: _____FIRST NAME: _____DATE:_____

GENDER (M/F): _____ DOB (MM/DD/YYYY): _____AGE: _____SSN#:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

OCCUPATION_____WHO REFERRED YOU?_____

CONTACT INFORMATION:

Home Phone: _____Cell Phone: _____Work Phone: _____

Personal Email: _____

*If under the age of 18 parent or guardian information:

Phone#:_____Name:_____Relation:_____

VISION INSURANCE:

Name of Ins: _____Policy Holder's Name:_____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Name of 2ND Ins: _____Policy Holder's Name:_____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

MEDICAL INSURANCE:

Name of Ins: _____Policy Holder's Name:_____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing service 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 to conduct healthcare operations involving our office. By signing this form below, I acknowledge that I have received the Notice of Privacy Practices from Family Optometric Vision Care.

Financial Responsibility Waiver

Insurance Authorization, Verification, and Co-Payments are the responsibility of the member. I understand that if my insurance benefits and/or eligibility are not approved by my health plan, then I am financially responsible and agree to pay for all charges related to services provided by Family Optometric Vision Care. This waiver will remain valid from this day forward to include all futute services related to this patient.

Signature (or Guardian)_____Date _____