PATIENT INFORMATION

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thank you for your cooperation.

NAME				DATE OF BIRTH	
ADDRESS		CITY/ STATE		ZIP	
HOME PHONE		WORK PHONE			
CELL PHONE		EMAIL			
EMERGENCY CONTACT NAME		PHONE		RELATIONSHIP	
EMPLOYER				OCCUPATION	
SOCIAL SECURITY NUMBER				SEX	______M ______ F

INSURANCE INFORMATION

INSURANCE CO.	ID NUMBER	SUBSCRIBER	SUBSCRIBER ID / SS #	SUBSCRIBER BIRTHDATE
PRIMARY VISION				
SECONDARY VISION				
PRIMARY MEDICAL				
SECONDARY MED.				

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I have read the Notice of Privacy Practices for this office. A copy for your personal records will be furnished upon request.

X_________________________________ Date _____________________

AUTHORIZATIONS

By signing below, I authorize treatment for services and acknowledge that I am responsible for payment for the services rendered. In the event that I am insured, I request that payment of authorized insurance benefits for any services furnished me be made on my behalf to Whidbey Vision Care PS. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X_________________________________ Date ______________________