Date:

Welcome to Our Office

To Help Us With Your Visual and Ocular Health Care, Please Fill Out the Following Form

****Please make sure we have a copy of your current insurance card****

PATIENT

Name: ____________________
Last First MI Suffix

Address: ____________________
Street

____
City State ZIP

Home #: ________ **Work #:** ________ **ext.** ____

Cell #: ________ **Email:** ________

SS#: ________ **DOB:** ________ **Sex:** ____

RESPONSIBLE PARTY

Relation to Patient: ________ *Self*

Name: ____________________
Last First MI Suffix

Address: ____________________
Street

____
City State ZIP

Home #: ________ **Work #:** ________ **ext.** ____

Cell #: ________ **Employer:** ________

SS#: ________ **DOB:** ________

Appointment Reminders: I prefer to contact via my: ☐ **Home #** ☐ **Work #** ☐ **Cell #** ☐ **Email**

PRIMARY INSURANCE

Ins Name: ____________________

Ins ID#: ________ **Employer:** ________

Relation to Patient: ________ ☐ *Self* ☐ *Resp Party*

Name: ____________________
Last First MI Suffix

Address: ____________________
Street

____
City State ZIP

DOB: ________

SECONDARY INSURANCE

Ins Name: ____________________

Ins ID#: ________ **Employer:** ________

Relation to Patient: ________ ☐ *Self* ☐ *Resp Party*

Name: ____________________
Last First MI Suffix

Address: ____________________
Street

____
City State ZIP

DOB: ________

MEDICAL HISTORY

Tobacco: ________

Alcohol: ________

Drugs: ________

Medical Dr: ________

DRUG ALLERGIES

________ ________

________ ________

MEDICATIONS

________ ________ ________

________ ________ ________

________ ________ ________

________ ________ ________

________ ________ ________

________ ________ ________

☐ **DECLINE TO ANSWER ALL**

HEALTH CARE REPORTING

1 - Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer Ethnicity

2 - Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Answer Race

3 - Primary Language: ☐ English ________ ☐ Decline to Answer Language

Please note that for your convenience we will bill your insurance company if your card is presented at the time of service If for any reason the insurance does not pay what is estimated, or delays payment more than 60 days, the balance will become the patient's responsibility. We will work with you to get your deserved benefits, but the patient and/or guardian is responsible for payment to this office. The relationship is between you and your insurance carrier, NOT between our office and your insurance carrier.

Authorization to Release Information: I hereby authorize this office to use and release any health information to treat me, obtain payment for services and to perform health care operations.

Authorization to Notify: I hereby authorize Defiance Optometric Group to notify me by telephone, mail, or other forms of communication If this is unacceptable, I will notify the office of the issue.

Authorization to Pay Benefits: I hereby authorize payment directly to this office by the government or major medical insurance carrier on my behalf. I authorize a photocopy of my signature to be used

I HAVE BEEN GIVEN AND HAVE HAD THE OPPORTUNITY TO READ DEFIANCE OPTOMETRIC GROUP'S PRIVACY POLICIES AND PROCEDURES. I MAY REQUEST A COPY OF THIS POLICY AT ANY TIME.

Signature: ____________________ **Date:** ________