Professional Vision Center

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PATIENT INFORMATION FORM

This information is used exclusively to help us provide the highest quality of professional services and ophthalmic products for your personal needs.

- Family doctor: _____ Phone: ( ) _____
- Other doctor(s)*: _____ Phone: ( ) _____

** Any other doctor(s) you see and with whom you would like us to share your visit information*

Last Name: _____First Name: _____M.I. _____

Date of Birth: / / Gender: Male Female SSN:

Phone: Home: ( ) _____ Cell: ( ) _____ Daytime: ( ) _____

May we leave a voicemail at the above numbers: Yes _____ No _____

Street Address: _____City: _____ State: _____ Zip: _____

Patient's Employer: _____ Occupation: _____

Insured Party: _____ Date of Birth:_____ Employer:_____

Emergency Contact: _____ Relationship:_____

Telephone #: ( )_____ Are we able to leave messages with this person? Yes ___ No ___

Please list family members or persons we may talk to about your vision/medical information:

_____

Vision Insurance: Company: _____ Medical Insurance: Company _____

Email Address: _____

How did you hear about our office? _____

Please initial before each paragraph to indicate your agreement to it and sign below:

X _____State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described in Professional Vision Center's notice of privacy practices. This notice takes effect September 23, 2013 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided the law permits the changes. Before we make significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office. All information about how your medical information may be used is described in this notice. By signing this form, you have acknowledged our Privacy Practices and that a copy of the Professional Vision Center Notice of Privacy Practices has been made available to you.

Professional Vision Center is required by law to maintain the privacy of our patients' health information. Unless you have signed a form authorizing the use or disclosure, we will not disclose your health information for any purpose other than Professional Vision Center's role in the treatment, payment, or for health care operations. With your signature below, we may disclose your health information to others, including designated family members, friends, or others who are involved in your health care or in payment for your healthcare.

X____My signature below authorizes third party payment of medical benefits to be made to Professional Vision Center, LLC. I understand that authorizations obtained prior to claim submissions do not guarantee payment by the insurance company. Professional Vision Center will submit insurance claims on my behalf and will forward a statement to me based on the explanation of benefits received from my insurance company. I understand that I am responsible for all payments due after receipt of the explanation of benefits.

Signature:_____ Date:_____