



Ms. Miss Mrs. Mr. Dr. PhD _____

Date of Birth: _____

Address: _____

Home Ph: _____

City/State/Zip: _____

Work Ph: _____

SSN: _____ Email: _____

Cell Ph: _____

Parents' name (if minor): _____

Single Married Life partner

Employer: _____ Occupation: _____ Full time Part time Full-time Student

Insurance co. #1: _____ vision medical Subscriber: _____ DOB: _____

Contract #: _____ HMO PPO traditional group #: _____

Insurance co. #2: _____ vision medical Subscriber: _____ DOB: _____

Contract #: _____ HMO PPO traditional group #: _____

Primary care physician: _____ Phone: _____

Address: _____

Hobbies, special vision needs: _____

I wear glasses: yes no I have had laser corrective surgery: yes no interested in LASIK? yes no

I wear contact lenses: yes no Type: _____ I replace my contacts every: _____

When was your last eye exam? _____ Name of previous eye doctor: _____

Referred by: _____ Doctor Friend Family Insurance co. advertisement

Due to the Health Insurance Portability and Accountability Act your initials & signature are required below

Initials:

Empty box for initials

I *authorize* any holder of medical information about me to release to my insurance company or its agent any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized services be made on my behalf to Ann Arbor Optometry. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance company.

OR

I *decline* the above information release and am solely responsible for fees. I understand that fees are due at time of service.

Empty box for initials

Empty box for initials

I authorize any holder of medical information about me to release and/or request my medical information with other health care professionals for the purpose of consultation and referral as appropriate for my health care.

Empty box for initials

I have been provided the Ann Arbor Optometry Privacy Policy. [You may request a copy for your records]

Signature _____ Relationship to patient _____ Date _____