ANN ARBOR optometry

Ms. Miss Mrs. Mr. Dr. PhD:_____ Gender: ☐ Male ☐ Female

Address: _____ Date of Birth: _____

City/State/Zip: _____ Primary Phone: _____

SSN: _____ Email: _____ Secondary Phone: _____

Parents' name (if minor): _____ ☐ Single ☐ Married ☐ Life Partner

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

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In accordance with the new healthcare guidelines, we are required to obtain the following information:

Preferred Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ Not Disclosed ☐ White

Ethnicity : ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Not Disclosed ☐ Not Hispanic or Latino

Communication Preference: ☐ Telephone ☐ Email ☐ Mail

Vision Insurance Co: _____ Subscriber: _____ DOB: _____

Contract #: _____ Group #: _____

Subscribers address if different from patient:_____

Medical Insurance Co: _____ Subscriber: _____ DOB: _____

Contract #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Subscribers address if different from patient:_____

*Please give your medical insurance card to the front desk

I wear glasses: ☐ yes ☐ no I have had laser corrective surgery: ☐ yes ☐ no I am 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

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

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.

AND

☐ 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.

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

Signature: _____ Relationship to patient: _____ Date: _____