



Name: _____

Sex at Birth: 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

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

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: _____