

PATIENT INFORMATION

NAME _____ (Dr. Mr. Mrs. Miss Ms.) circle one BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

E-MAIL ADDRESS _____

PATIENT EMPLOYER _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE _____ ALTERNATE PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

PRIMARY INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE: Medicare (please circle) or Other: _____

SECONDARY INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE: Medicare (please circle) or Other: _____

OTHER or VISION INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE : _____

GUARANTOR INFORMATION -same as patient YES _____ NO _____ please complete if No is your answer

GUARANTOR'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

I hereby authorize the release of the necessary medical information to process claims and direct payment of benefits to Clavenna Vision Institute. I understand I am responsible to pay all non-covered services, co-pays, and deductibles. I understand if my insurance requires a referral authorizing services and I fail to bring a referral, I will be responsible for all charges. I understand that I may incur collection fees related to overdue balances.

SIGNATURE OF PATIENT, GUARANTOR (IF PATIENT IS A MINOR),

DATE

LEGAL GUARDIAN OR LEGAL REPRESENTATIVE

UPDATE SIGNATURES (FOR FUTURE APPOINTMENTS)

Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date

Sign in section A OR B (not both)

A

AUTHORIZATION TO RELEASE RECORDS

I AUTHORIZE THE PERSON(S) NAMED BELOW TO DISCUSS MY CARE IN MY ABSENCE AND OBTAIN MY MEDICAL RECORDS IF NECESSARY. (THIS DOES NOT INCLUDE DOCTORS). I UNDERSTAND THIS AUTHORIZATION IS IN EFFECT UNLESS I REVOKE THE AUTHORIZATION IN WRITING.

DESCRIPTION OF THE SPECIFIC INFORMATION TO BE DISCLOSED:

ALL MEDICAL RECORDS

NAME	RELATIONSHIP	PHONE

PATIENT SIGNATURE

DATE



B

I HAVE READ THE ABOVE INFORMATION AND, AT THIS TIME, ELECT NOT TO AUTHORIZE THE RELEASE OF ANY RECORDS. I UNDERSTAND THAT BY SIGNING THIS BOX I AM PREVENTING MY SPOUSE, CHILDREN OR CAREGIVER TO ACCESS MY RECORDS. I CAN REVOKE THIS REQUEST IN WRITING AT ANY TIME.

PATIENT SIGNATURE

DATE