

**PLEASE COMPLETE ALL INFORMATION**

**PATIENT INFORMATION**

NAME \_\_\_\_\_ (Dr. Mr. Mrs. Miss Ms.) circle one BIRTHDATE \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ PHONE # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_  
other than spouse or parent  
WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_  
PRIMARY CARE PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
PATIENT EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE PLAN NAME \_\_\_\_\_ DO YOU HAVE MEDICARE? YES NO  
SPOUSE'S NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SPOUSE EMPLOYER \_\_\_\_\_ PHONE# \_\_\_\_\_  
INSURANCE PLAN NAME \_\_\_\_\_

**INSURANCE & GUARANTOR INFORMATION IF MINOR**

FATHER'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
ADDRESS (IF DIFFERENT THAN PATIENT) \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_  
.....  
MOTHER'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
ADDRESS (IF DIFFERENT THAN PATIENT) \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

**I hereby authorize the release of the necessary medical information to process claims and direct payment of benefits to Clavenna Vision Institute. I am responsible to pay all non-covered services, co-pays, and deductibles. If my insurance requires a referral authorizing services and I fail to bring a referral, I will be responsible for all charges.**

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT(IF PATIENT IS A MINOR),  
LEGAL GUARDIAN OR LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

**UPDATE SIGNATURES (FOR FUTURE APPOINTMENTS)**

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

Date \_\_\_\_\_ over \_\_\_\_\_

**SIGNATURE REQUIRED IN SECTION A OR B**

**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