NEW PATIENT PAPERWORK

Full Name: _____ Birthdate: _____

Address: _____ Social Security # : _____

City/State/Zip: _____ Home # : _____

Email: _____ Cell # : _____

Occupation: _____ Work # : _____

Marital Status: Single/Married/Divorced/Widowed Preferred Language: _____

How did you hear about us? ___Phone Book ___Web ___Patient (list below) ___Other (list below)

Check to receive: ___Email ___Texts (about appointments/glasses/contacts) List here _____

Race: Please check all that apply **Ethnicity: Please check (only one please)**

Black or African American		Native Hawaiian/Other Pacific Island	
White		Hispanic or Latino	
Hispanic		Not Hispanic or Latino	
Asian			
Native Hawaiian/Other Pacific Island			
American Indian or Alaska Native		Do not want to specify	

Person Responsible for Account (if a minor)

Full Name _____

Relation to Patient _____ DOB _____ SS#_____

Full Address (if different from patient) _____

Phone _____

Insurance Policy Holder Information (if other than patient)

Full Name _____

Relation to Patient _____ DOB _____ SS# _____

Full Address (if different from patient) _____

Phone _____

Authorization for Disclosure of Information

I authorize the disclosure of the following to the named individual's listed below.

___ Records ___ Appointments ___ Account/Billing Information ___ Pick Up: Glasses/Contacts/Prescriptions

Name: _____ Name: _____

Name: _____ Name: _____

May we release your medical information to other doctors: ___YES ___ NO

May we request your medical information from other doctors: ___ YES ___ NO

May we leave you a message on an answering machine or voicemail: ___ YES ___ NO

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Signature of patient or legal representative _____ Date _____

****PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED****

LIKE US and CHECK IN on FACEBOOK!