



PATIENT INFORMATION FORM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____ Male Female Other Age: _____ Single Married Other
Birthdate: _____ Height: _____ ft. _____ in. Weight: _____ lb. SS#: _____
E-Mail: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____
Address: _____ City: _____ State/Zip: _____
Patient's Occupation: _____ Employer/School: _____
Business Address: _____
Spouse's/Parent's Name: _____ Work Phone: _____
Spouse's/Parent's Occupation: _____ Employer/School: _____
Name of Emergency Contact: _____ **Day Phone:** _____
Ethnicity: Hispanic Y N Race: Am Indian/Alaska Native Asian Black Pacific Islander White

PERSON RESPONSIBLE FOR ACCOUNT

If patient is responsible for own account, just list SELF.

Name: _____ SS#: _____
Address: _____
City: _____ State/Zip: _____ Home Phone: _____
Relationship to Patient: _____ Employer/School: _____
Business Address: _____ Work Phone: _____

INSURANCE INFORMATION

Vision Insurance Company: _____ Insured's ID#: _____
Insured's Name: _____ Relationship to Patient: _____
Birthdate of Insured: _____ SS#: _____ Employer Name: _____
Primary Medical Insurance Company: _____ Insured's ID#: _____
Insured's Name: _____ Relationship to Patient: _____
Birthdate of Insured: _____ SS#: _____ Employer Name: _____

ASSIGNMENT & AUTHORIZATION

1. I am financially responsible for all charges whether or not paid by insurance. I understand that Northside Vision will bill my insurance as a courtesy to me, but Northside Vision is not responsible for collecting or negotiating settlements with my insurance carrier(s). I hereby authorize my insurance company(s) to pay Northside Vision directly.
2. Additional procedures and services may be deemed medically necessary. These additional services will be discussed with me prior to being performed. I hereby authorize the physician and/or assistants to administer any treatment as may be deemed necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of my examination or treatments performed.
3. All optical materials require a 50% deposit at the time of ordering, with the balance due at time of delivery.
4. Northside Vision may disclose health information to my insurance company and their agents for the purpose of determining insurance benefits and obtaining payment for services rendered. Contact lens services are NOT included in a routine eye examination and will be billed as a separate charge.
5. A \$50 service charge will be assessed on all NSF checks.
6. Privacy practices have been established to comply with the privacy rules under the Health Insurance Portability And Accountability Act (HIPAA). I have been informed of my right to view Northside Vision's HIPAA policies.

Signature: _____

Date: _____