WEST MILTON
VISION CENTER

PATIENT INFORMATION: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

☐ Caucasian ☐ African Amer. ☐ Asian ☐ Native Amer.
☐ Pacific Islander ☐ Hispanic ☐ Prefer not to say

Social Security Number | Date of Birth

Primary Phone (include area code) | Daytime Phone | Email Address (if we may contact you by email)

Occupation

INSURANCE INFORMATION:
Information of person responsible for bill:

First Name | MI | Last Name | Primary Phone (include area code)

Street Address (if different from patient) | City | State | Zip

Do you have VISION insurance? Yes/No Not sure

Do you have MEDICAL insurance? ☐ Yes ☐ No Not sure Insurance Name:

Subscriber Information Insurance Name:

First Name | MI | Last Name | Social Security Number

Date of Birth

Patient's relationship to subscriber:
Self ☐ Spouse ☐ Child ☐ Student ☐ Domestic Partner ☐ Other

Please Read:
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices describes how to ask for a restriction.
I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations. I acknowledge that I have received and/or read the Notice of Privacy Practices from Optometric Associates.

Patient/Guardian Signature | Date