Welcome!

In order to serve you properly, we will need the following information.
Information will be strictly confidential. Please print & complete all items fully.

Today's Date: ______/______/________ *(MM/DD/YYYY)*

Patient's Last Name: ____________________________________

First Name: ____

Middle Initial: _____ **Preferred Name:** ___________________

Address: __________________________________ **Apt#:** _____

City: _________________ **State:** ______ **Zip code:** __________

Home Phone: ____

Daytime Phone: ____

Cell Phone: ____

May we text you to let you know your eye wear is ready for pick-up & to confirm future appointments? □ **Yes** □ **No**

E-mail: ____

Preferred form of contact: □ **e-mail** □ **postal** □ **telephone**

Patient's Birth Date: ______/______/________ *(MM/DD/YYYY)*

Social Security #: _____________________________________

Sex: M / F **Status:** Married / Single / Widowed / Divorced / Domestic Partnership

Race: □ Native American □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: __________________________________

Employer / School: ___________________________________

Occupation: ____

How did you first hear about St. Lucy's? [If through another patient, please write his/her name so we can send a thank-you.]

____

For minors, parent/guardian name(s) & address:

____

____

Vision Insurance Company: _______________________ **ID # (If Tricare, main member's SSN):** ________________________

Policy Holder's First & Last Name: ____________________________________ **Relationship to Patient**: ___________________

Medical Insurance Company: ______________________ **ID #**: ________________________ **Group #**: ___________________

Policy Holder's First & Last Name: ____________________________________ **Circle one**: **HMO plan** **not an HMO plan**

2nd Medical Insurance Company: ___________________ **ID #**: __________________________ **Group #**: ___________________

St. Lucy's Office Policies

I have read and understand the office policies of St. Lucy's Vision Center. → Please Initial: _________

Finance Agreement

I authorize this office to release any information necessary to expedite insurance claims. I authorize use of signatures on this form for insurance claim submissions. I authorize payment directly to my doctor. I understand that I am responsible for all charges, regardless of insurance coverage. All accounts past 60 days are subject to 1 ½ % finance charge – annual rate 18%.

↳ Patient, Parent or Guardian Signature: _______________________________________ Date: ___________________

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I received a copy of William H. Stephen, O.D. Notice of Privacy Practices.

↳ Patient, Parent or Guardian Signature: _______________________________________ Date: ___________________

I allow access to my patient records and information to someone other than me (please circle one below):

↳ YES or NO

↳ If YES, print name(s) of individual(s): _________________________________ Relationship to patient: ______________