Goldthwait Vision Care

Welcome to our practice. Thank you for choosing us for your eye care needs. Please complete and sign this form for our records.

How did you hear about our practice?

□ Yellow pages □ Internet search □ Patient referral
□ Radio advertisement □ TV advertisement □ Professional referral
□ Walk-in □ Other:_____ □ Current patient

□Mr. □Miss □Mrs. □Ms. □Dr. □Male □Female

_____ _____ _____ _____

Patient's First Name **MI** **Last Name** **Preferred Name**

_____ _____ _____

Mailing Address **City/Town** **State/Zip**

_____/_____/_____ _____ _____ _____

Date of Birth **Home Phone** **Cell or Work Phone** **Social Security #**

E-MAIL ADDRESS: _____*(We will NOT share this address with any outside entity. It is for our internal use only)*

INSURANCE #1:_____**SUBSCRIBER:**_____ **DOB:**_____

POLICY#_____**GROUP#**_____

INSURANCE#2:_____**SUBSCRIBER:**_____ **DOB:**_____

POLICY#_____**GROUP#**_____

Subscriber's address if different than home address:_____

OCCUPATION: ☐ Student ☐ Retired ☐ Employed by _____

MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

If patient is a minor, name of Parent or Guardian: _____DOB_____

Primary Care Physician: _____ **Phone:** _____

Acknowledgement of Receipt

I acknowledge that I have reviewed a copy of the Goldthwait Vision Care Notice of Privacy Practices (A copy is available upon request at the receptionist desk)

Patient Signature: _____ Date: _____

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Insurance Waiver

I, _____, understand that all services performed on this date will be billed to my insurance company and that ANY charges that are not covered by my insurance will be my responsibility. I give my permission for this office to release my medical records to my insurance company to expedite any medical claims filed on my behalf. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Patient Signature: _____ Date: _____
(or signature of parent/guardian if patient under 18)

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Waiver for Self-Referred Services

I, _____, understand that I am seeking the care of this specialty physician without a referral from my primary care physician. I understand that the terms of my health care coverage may require that I obtain a referral for specialty services and that I have two weeks to obtain a referral from my primary care physician or I may be responsible for all charges of the services rendered. I understand that benefits are subject to the terms, conditions, exclusions, and limitations of my plan documents, including my certificate of coverage or summary plan description.

Patient Signature: _____ Date: _____
(or signature of parent/guardian if patient under 18)