ST. LUCY'S VISION CENTER

WELCOME TO OUR OFFICE

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

Today's Date: _____/_____/_____ *(MM/DD/YYYY)* **Patient's Birthdate:** _____/_____/_____ *(MM/DD/YYYY)*

Last Name: _____ **First Name:** _____ **Middle Initial:**_____

Social Security #: _____ **Sex**: Male / Female **Marital Status**: Married / Single / Widowed / Divorced

Race: z American Indian or Alaska Native z Asian z Black or African American z Native Hawaiian or Other Pacific Islander z White

Ethnicity: z Hipanic or Latino z Not Hispanic or Latino **Preferred Language:** _____

Preferred Method of Contact: z Email z Postal z Telephone **Cell Phone Text Okay?** z Yes z No

Street Address: _____ **Apt #**: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Daytime Phone**: _____ **Cell Phone**: _____

Email Address: _____

Employer / School: _____ **Occupation**: _____

Driver's License # / State: _____ **How did you hear about our office?** _____

If patient is a minor, parent or guardian name(s): _____

Guardian's Address: _____

Vision Insurance Company: _____ **ID #:** _____

Policy Holder's Name: _____ **Relationship to Patient**: _____

Medical Insurance Company: _____ **Policy #**: _____ **ID#**: _____

Policy Holder's Name: _____ **Relationship to Patient**: _____

2nd Medical Insurance Company: _____ **Policy #**: _____ **ID#**: _____

Policy Holder's Name: _____ **Relationship to Patient**: _____

St. Lucy's Office Policies

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

Medicare / Insurance Release

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: _____/_____/_____
(MM/DD/YYYY)

HIPAA Compliance Acknowledgement of Receipt

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

Allow access to all patient records and information to: *(none or full name/relationship)*_____

Patient, Parent or Guardian Signature: _____ Date: _____/_____/_____
(MM/DD/YYYY)