BAUER & CLAUSEN
OPTOMETRY

Confidential Patient Information

First Name_____ Middle Initial____ Last Name_____

Preferred Name_____ Date of Birth_____ Gender_____

Address_____ City, State, Zip_____

Phone Number: Home_____ Cell_____ Preferred ☐Home ☐Cell

Employer_____ Social Security Number_____

Emergency Contact: Name _____ Phone _____ Relationship _____

Email Address_____

How did you hear about our office?

☐Internet ☐ Drive-By ☐ Family/Friend/Co-worker_____
Please share their name so we can thank them!

☐Insurance ☐Mail ☐Facebook ☐Magazine ☐ Other_____

Person Responsible for Account/Payment ☐ Check here if information is same as above.

First Name_____ Middle Initial____ Last Name_____

Address_____ City, State, Zip_____

Phone Number: Home_____ Cell_____ Relationship_____

Date of Birth_____ Social Security Number_____

Family Dependents (Only for family members the age of 17 and under that have appointments same day.)

Name_____ Date of Birth _____Relationship_____

Name_____ Date of Birth _____Relationship_____

Name_____ Date of Birth _____Relationship_____

Name_____ Date of Birth _____Relationship_____

Name_____ Date of Birth _____Relationship_____

Name_____ Date of Birth _____Relationship_____

I understand that I am responsible for all charges for services and products received. I allow Bauer & Clausen Optometry to bill my insurance company for payment. I have read and agree to the financial policy of Bauer & Clausen Optometry.

Signature _____ Date _____

I have read and have access to the Notice of Privacy Practices.

Signature _____ Date _____