BAUER & CLAUSEN
OPTOMETRY

Confidential Patient Information

First Name_______________________ Middle Initial____ Last Name____________________________

Preferred Name___________________ Preferred Language_____________________ Gender: M / F

Address_________________________________ City, State, Zip_____________________________________

Phone Number: Home____________________ Cell__________________ Work____________________

Emergency Contact: Name _________________ Phone _______________ Relationship __________

Date of Birth______________________ Social Security Number_________________________________

Race/Ethnicity: Caucasian/Native American/African American/Asian/Hispanic/Other

Occupation_____________________________ Employer_____________________________________

Email___________________________________ Spouse______________________________

How did you hear about our office?

☐Internet ☐Referred by Family/Friend/Co-worker___________________________
Please share name so we can thank them!

☐Insurance ☐Radio ☐Facebook ☐Magazine ☐ Other_________________

Person Responsible for Account/Payment

First Name_______________________ Middle Initial____ Last Name___________________________

Address_________________________________ City, State, Zip___________________________________

Phone Number: Home____________________ Cell__________________ Work___________________

Date of Birth______________________ Social Security Number_______________________________

Insurance and HIPAA

We are happy to provide the service of filing your insurance for you (if we are providers for your plan), and we request that you provide us with as much information about your insurance (including a copy of your card) as possible AT THE TIME OF SERVICE so we can file/bill them correctly.

Vision Insurance____________________________
Policy Holder______________________________
Relationship to Patient____________________
Policy Holder's Birth Date___________________
Policy Holder's SS#________________________
Policy Holder's Employer___________________

Medical Insurance______________________________
Policy Holder_____________________________________
Relationship to Patient____________________________
Policy Holder's Birth Date__________________________
Policy Holder SS#________________________________
Policy Holder's Employer__________________________

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 ____________