GUNDERSON EYECARE

Patient Information

Date: _____/_____/_____

Full Name: _____ **Date of Birth:** _____/_____/_____

Please add your middle initial to your full legal name.

Address: _____

Street Address *Apt./Unit #* *City* *State* *ZIP Code*

Social Security/Government ID: _____

Who is your employer? _____ Job Title: _____

Marital Status: Single Married Divorced Widowed Other

Spouse's Name: _____

Guardian or Spouse's Employer: _____

Guardian or Spouse's Work Number: _____

Family Physician: _____

Who can we thank for referring you? _____

Race and Ethnicity: White Hispanic or Latino African American

Asian American Indian or Alaska Native Pacific Islander

Other: _____

Preferred Language: English Spanish Korean Chinese Tagalog Vietnamese

Other: _____

Preferred Gender: Male Female Other: _____

Gender on Insurance: Male Female

Contact Information

Write 1, 2, or 3 on the line for the order in which you prefer to be contacted.

Text: _____ **Call (Cell):** _____ **Call (Home):** _____ **Call (Work):** _____ **E-mail:** _____

Cell: _____ Work: _____ Home: _____

E-mail: _____

Insurance Policy Holder Information

Are you the primary insurance holder? Yes No

(If "No", please fill out the following information. If "Yes", please sign and date.)

Full Name: _____ **Date of Birth:** _____/_____/_____

Last *First* *M.I.*

Social Security/Government ID: _____**Employer:** _____

I give Gunderson Eyecare permission to bill my insurance company and to release any pertinent information that is needed to process my claim.

Signature: _____ **Date:** _____/_____/_____

I agree to receive my glasses and contact lens prescription electronically.

Patient Signature or Parent/Guardian Signature: _____

HIPAA Notice of Privacy Practice and Medical Release

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. **A Copy of the HIPAA Notice of Privacy Practices will be provided to you upon request.**

I also give permission to share information pertaining to my care to the following person(s):

1: Name: _____ **Relationship:** _____

2: Name: _____ **Relationship:** _____

3: Name: _____ **Relationship:** _____

By signing this document, you signify that you have read and agree to the statements listed above. You can revoke this agreement in writing at any time prior to treatment. Your signature will remain on file indefinitely, unless revoked by you or your representative.

Patient Signature or Parent/Guardian Signature: _____

Printed Patient's Full Name: _____ Date: _____/_____/_____

Witness's initials: _____

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