Patient Name (last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (m.i.) \_\_\_\_\_

Nickname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip\_\_\_\_\_\_\_

Pt DOB (mm/dd/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: **Texting / Cell # / Home # / Work # or Email** (circle one)

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find us? Google? Yelp? Insurance? Referral from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen **any** of our doctors before? **Y / N** If yes, which doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_How long ago? \_\_\_\_\_\_

Marital Status:  **Single** / **Married** / **Divorced**  / **Widowed** Do you plan on using any insurance?  **Y** or **N**

Medical insurance: **Aetna / BCBS / Humana / UHC / Medicare** / **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision insurance: **Aetna Vision / BCBS / EyeMed / Spectera / VSP / VCD / VCP / Other** \_\_\_\_\_\_\_\_\_\_\_\_

Are you the primary account holder on your insurance? **Y** or **N**  (*If NO, please fill primary info below*)

Primary member’s name (last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (mm/dd/yy) \_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

**Vision Examinations**: For “routine eye examination”, glasses prescriptions and/or contact lens fitting are billed through your vision insurance plan. Contact lens fitting/exams require additional follow up care. Vision insurance can only be used for prescribing vision correction (refractions). Most medical insurances cannot be used for “routine refractions” and the purchase of contacts or glasses.

**Medical Examinations**: For treatment of eye irritation or infection, glaucoma, macular degeneration, diabetic retinopathy, and/or other eye problems. Medical eye examinations require more time, documentation and additional professional judgment to identify the reason and the appropriate treatment. Vision insurance plans such as EyeMed or VSP cannot be used for medical examinations.

**ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE**

PATIENT ASSUMES FULL RESPONSIBILITY FOR PAYMENT OF SERVICES, COURT COST, ATTORNEY FEES, AND ANY OTHER COST INCURRED DURING COLLECTION OF DELINQUENT ACCOUNTS. AN ADDITIONAL $35 CHARGE WILL BE ADDED TO ANY RETURNED CHECK. ***PROFESSIONAL SERVICE FEES ARE NOT REFUNDABLE. EYEGLASSES ARE CUSTOM ORDERED TO FIT EACH INDIVIDUAL AND CANNOT BE RETURNED OR REFUNDED*** **(REFER TO OUR OPTICAL POLICIES).** NO REFUNDS/EXCHANGES ON OPEN BOXES OF CONTACTS. PRESCRIPTION RECHECKS AVAILABLE AT NO CHARGE FOR UP TO 60 DAYS FROM THE ORIGINAL EXAM DATE, FEES APPLY AFTER 60 DAYS.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY & INFORMATION RELEASE CONSENT

I AUTHORIZE ANY HOLDER OF MEDICAL OPTICAL INFORMATION TO RELEASE INFORMATION ABOUT ME TO DR. DAVID J ANDERSON & ASSOCIATES AND I AUTHORIZE DR. DAVID J ANDERSON & ASSOCIATES TO RELEASE MEDICAL OPTICAL INFORMATION ABOUT ME TO OTHER HEALTHCARE PROFESSIONALS, ATTORNEYS OR INSURANCE COMPANIES.

I HEREBY ACKNOWLEDGE THAT I READ AND UNDERSTAND THE ABOVE INFORMATION. I ALSO HAVE BEEN PRESENTED AND OFFERED A COPY OF THE NOTICE OF PRIVACY POLICY FOR THE OFFICE OF DR. DAVID J ANDERSON & ASSOCIATES.

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**