WELCOME TO THE *EYES ON CARSON* OFFICE
Your confidentiality is our top priority. Information will only be shared with your consent.

Last Name First Name Middle Initial	Preferred name	Birth date	Age	Sex F/M

Mailing Address	City	State	Zip code

Do you want recalls/appointment reminders? **Cell# and/or email**:

Social Security # (or last 4)	Occupation	Other phone #: this is work/home (circle)

Vision Plan	ID #	Name of insured	Birth date of insured	Related how?
Medical Insurance	ID #	Name of insured	Birth date of insured	Related how?

Optional:	Race:	Ethnicity:	Preferred language: English/Spanish Other_____

Authorization statement:
I confirm my reported health history is complete to the best of my knowledge. I accept responsibility for payment of any portion of services rendered which are not covered by my vision plan or medical insurance. PERMISSION IS GRANTED FOR THE RELEASE OF ALL MEDICAL INSURANCE INFORMATION. I REQUEST THE ASSIGNMENT OF BENEFITS TO THIS PROVIDER.

X_____ _____
Signature of Patient OR Guardian Date

❑ Yes, I would like a copy of this office's Notice of Privacy Practices. I understand that this document provides information regarding how my protected health information will be used by this office.

❑ No, I decline a copy of this office's Notice of Privacy Practices. I am aware that I may obtain this information at any time by contacting Eyes on Carson at 775.267.2000.

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❑ Patient or guardian has declined to accept or sign acknowledgement form.

_____ _____
Signature of Patient or Guardian Date