

ANDERSON & CHHABRA EYECARE CENTER

Bruce W. Anderson, O.D. • William O. Malone, Jr., O.D.
Neeta Chhabra, O.D.

Last Name _____ Jr. Sr. III

Male / Female (please circle one) Date of Birth ____/____/____

First Name _____ MI _____

Social Security # ____/____/____

What name would you like the doctors and staff to call you?

Marital Status: Married Single Divorced Widowed Other (please circle one)

Address _____

Employment Status: Full Time Unemployed Full-Time Student
Part Time Home-maker

Apt # _____ City _____

Employer _____

State _____ ZIP _____

Occupation _____

Home Phone _____

Driver's License # _____ State _____
(of adult or parent/guardian)

Work Phone _____

Insurance (Vision) _____

Cell Phone _____ Texting OK Yes / No

(Medical) _____

Fax # _____

Preferred Language _____ (English, Spanish)

Email _____

Race: American Indian or Alaska Native, Black or African American,
Asian, Native Hawaiian/Other Pacific Islander, White

(Anderson EyeCare Center may send special offers/communication)

Ethnicity: Hispanic or Latino, Hawaiian/Other Pacific Islander,
Not Hispanic or Latino

Referred By: _____

Communication Pref.: Email, Postal, Telephone

PLEASE READ AND SIGN

- In the event that my account becomes overdue, I agree to reimburse the fees of any collections agency, which may be based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonably attorney's fees, we incur in such collection efforts.**
- As a courtesy, Anderson EyeCare Center will submit claims on my behalf to my Primary Insurance (provided the Doctor has a contract with my insurance company). It is my responsibility to submit claims to any second or third insurance, if applicable.**
- I understand that I am responsible to Anderson EyeCare Center for applicable co-payments, deductibles, and non-covered services remaining after my insurance has paid.**
- I understand that it is my responsibility as a patient to know and understand my insurance coverage. Anderson EyeCare Center will try to assist me in receiving maximum benefits from my insurance.**

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT:

I have received a copy of the "Notice of Privacy Practices" for Anderson EyeCare Center written in plain language. This notice provides the uses and disclosures of my protected health information that may be used by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information. I understand this practice has the right to change the terms of its "Notice of Privacy Practices", and to make changes regarding all protected health information resident at, or controlled by this practice.

I authorize Anderson EyeCare Center to discuss my health/account information with the following person(s). Print the person(s) full name. Please write N/A on line 1, 2 and 3 if you do not wish to have your personal information discussed with anyone. If you wish to revoke this, you may do so at any time IN WRITING.

1. _____ 2. _____ 3. _____

Signature (Adult/Parent) _____ Date: ____/____/____

Print Name _____ Date Of Birth ____/____/____

Relationship to Patient: _____ Social Security # ____/____/____