KLEMP OPTOMETRY
1910 IDAHO STREET
LEWISTON, ID 83501-2564
(208)743-4022

Patient Registration

Date of Exam: _____

Please review, make necessary changes and supply any missing information.

Patient Name				**Salutation**	
Date of Birth		**Age**		**Birth State**	
Sex				**SS #**	
Address					
Address Type				**Country**	
Home Phone #	( ) -	**Work Phone #**		**Extension**	
Cell Phone #		**Email**			

Insurance			
Company		**ID #**	
Insured		**Date of Birth**	
Vision Coverage?			
Company		**ID #**	
Insured		**Date of Birth**	
Vision Coverage?			

Release Of Medical Information - Status				
Name	**Relationship**	**Phone number**	**Date of Birth**	**Release Status**
				☐ Medical ☐ Billing
				☐ Medical ☐ Billing
				☐ Medical ☐ Billing

Name of Medical Doctor:_____ Preferred Pharmacy:_____

- *By signing below, I am attesting that the information that I have supplied is true to the best of my knowledge. I authorize release of my information to and from my insurance company or other co-managing doctor. I also authorize Klemp Optometry to bill Medicare and/or my private insurance company.*
- *Klemp Optometry cannot guarantee anything about the undersigned's insurance, as the contract is between the undersigned and their insurance company, not with this office. We will assist in providing information, but it is the responsibility of the undersigned to know their insurance benefits and eligibility. I agree to be financially responsible for any balance not paid by my insurance plan. I understand that professional fees (i.e., comprehensive eye examinations, contact lens fittings, and medical office visit) are non-refundable.*
- *I respect Klemp Optometry's policy of 50% down upon ordering glasses or contact lenses, unless special arrangements have been made with the Office Manager.* ***Once I have submitted an order, I understand there will be no refunds on canceled orders.***

Patient/guardian signature: _____

Internal Usage Only
Patient: Acct: Today's Date: _____