Harrison Eye Care

Name _____ DOB: _____
Address _____
_____
Home Ph:_____ Day Ph:_____
Cell Ph: _____

Name Preference/Nickname: _____ Title (Please circle): Mr. / Mrs. / Ms. / Miss / Dr. / Other: _____

Age: ____ Birth Date: _____ Marital Status (please circle): Single/Married/Divorced/Widowed/Legally Separated

SSN (or last 4 digits **Required)**_____ Gender(Please circle): Male or Female

Email: _____

Communication Preference (please circle one): Postal / Home Phone / Cell Phone / Text / Email

For improved communication may we please send an email to notify you of the following: ___ Yes ___ No

- ✓Glasses/contact lenses ready for pickup
- ✓Appointment reminder/ annual recall notice (no more postcards!)
- ✓Newsletter (4 times per year)

Referred by (please circle): Patient/Professional/Other/None Name: _____
List other family members seen at this office: _____
Employer (or school): _____Occupation (or grade in school): _____

Required Information (please check <u>ONE</u> in <u>EACH CATEGORY</u>):

<u>Race:</u>
__ White
__ Black or African American
__ Hispanic
__ Asian
__ American Indian or Alaskan Native
__ Native Hawaiian/Other Pacific Islander

<u>Ethnicity:</u>
__ **Not** Hispanic or Latino
__ Hispanic or Latino
__ Native Hawaiian/Other Pacific Islander

<u>Preferred Language:</u>
__ English
__ Spanish
__ Japanese
__ French

➢ **I acknowledge receipt of Harrison Eye Care's Notice of Privacy Practices (please initial) _____**
(The Harrison Eye Care Privacy Policy is available for review at the front desk. Copies are available upon request.)

Person financially responsible for this account: _____ SSN (or last 4 digits): _____
How is this person related to patient (circle): Self/Spouse/Father/Mother/Guardian/Other _____
If minor, parents full names: Father _____ Mother _____

Do you have vision insurance through Vision Service Plan (VSP): Yes/No Medicare: Yes/No
If yes: Insured's Legal Name: _____ SSN (or last 4 digits)/ID#: _____

PAYMENT POLICY:
Payment is required at the time of service. You are responsible for all fees and will be reimbursed directly by your insurance carrier if you are eligible for coverage. Does not apply to Vision Service Plan (VSP) or Medicare.
Please circle your method of payment: Check Cash Visa Mastercard Discover

Patient/Guardian Signature: _____ Date: _____