Patient Information

Date: _____ Last: _____ MI: _____ First:_____
Address:_____ Home: ( )_____-_____
City: _____ State: _____ Zip: _____Cell: ( ) _____-_____
D.O.B: _____Work: ( )_____-_____Circle: Male or Female
Occupation: _____ Employer: _____
Email Address: _____ Marital Status: _____ Age:_____
How did you hear about us? _____
Is it okay to disclose your medical information to anyone? Yes or No
If yes, Please list: Name: _____Relationship: _____
Type of Vision Insurance: _____Card holder D.O.B._____
Type of Medical Insurance: _____ Card holder D.O.B._____

Please note: We are providers for some insurance programs. Please consult brochures for details regarding deductibles and maximum payments. Some procedures and material that are necessary may not be covered by insurance; these services are the responsibility of the patient. All insurance and discount cards must be presented at the tine of the examination. Patients are responsible for charges not paid by insurance.

I_____, authorize payment of benefits for services and assume responsibility for all charges. I also authorize the release of information necessary to this claim.
Signed: _____Date: _____
Relationship to Patient: _____.

Acknowledgement of Notice of Privacy Practices

The law requires that M. Andrew Durant OD, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I have read or had explained to me M. Andrew Durant OD, PLLC's Notice of Privacy Practices and agree to continue my care with M. Andrew Durant OD, PLLC under said terms.
I have read and understand this form. I am signing it voluntarily.

_____ _____
Patient Signature Date

_____ _____
Representative Relationship to Patient

OFFICE USE ONLY

Company: _____ Member ID: _____
Exam Co-pay: _____ Auth #: _____
Elg. Services: _____ Material Co-pay: _____