PATIENT INFORMATION

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.

MASON VISION CENTER

☐ M ☐ F

_____ ____ _____ _____
First Name   MI   Last Name   Preferred Name

_____ _____ _____ _____
Street Address   City   State   Zip

☐ Caucasian ☐ African Amer. ☐ Asian ☐ Native Amer.
☐ Pacific Islander ☐ Hispanic ☐ Other ☐ Prefer not to say

_____ _____
Social Security Number   Date of Birth

_____ _____ _____
Primary Phone (include area code) Daytime Phone   Email Address (if we may contact you by email)

Occupation _____ Are you a student? **Y   N**

How did you find us? ☐ Insurance ☐ Family ☐ Friend   Who were you referred by? _____
                    ☐ Close to home/work ☐ Other

INSURANCE INFORMATION

Information of person responsible for bill: Is this person a patient here? **Y   N**

_____ ____ _____ _____
First Name   MI   Last Name   Primary Phone (include area code)

_____ _____ _____ _____
Street Address (if different from patient**)**   City   State   Zip

Do you have VISION insurance?   ☐ Yes ☐ No ☐ Not sure   Insurance Name: _____

Do you have MEDICAL insurance?   ☐ Yes ☐ No ☐ Not sure   Insurance Name: _____

Subscriber Information

_____ ____ _____ _____
First Name   MI   Last Name   Social Security Number

_____ **Patient's relationship to subscriber:**
Date of Birth   ☐ Self ☐ Spouse ☐ Child ☐ Student ☐ Domestic Partner ☐ Other

Please Read:

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.

I acknowledge that I have received and/or read the *Notice of Privacy Practices* from Optometric Associates.

_____   _____
Patient/Guardian Signature   **Date**