Alameda Optometric Group

Welcome to Our Office

Patient Information

- ❑ Mr.
- ❑ Mrs. _____ _____
- ❑ Ms. First/Middle/Last (as shown on insurance card) Preferred Name
- ❑ Dr.

Date of Birth: _____/_____/_____ □ Female □ Male

Address: _____ City: _____ State: ____ Zip: _____

Social Security # (last 4 digits only): _____ Email Address: _____

Phone #: _____ _____ _____
Home Work Cell

Preferred Method of Communication: (check one) □ Phone □ Email □ Text □ Postal

Occupation**:** _____ **Employer:** _____

Spouse's/Parent's Name: _____

Referred by: _____ Send a thank you note? □ Yes □ No

Primary Vision Insurance **□ VSP □ MES □ Other** _____

Who is the Policy Holder? □ Self □ Spouse □ Child □ Domestic Partner □ Other _____

Insured's Name/DOB (if different from patient): _____
Social Security # (last 4 digits only): _____ (Name and DOB exactly as shown on insurance card)

Patient's Status: □ Single □ Married □ Widowed □ Child □ Full-time Student

Secondary Vision Insurance **□ VSP □ MES □ Other** _____

Who is the Policy Holder? □ Self □ Spouse □ Child □ Domestic Partner □ Other _____

Insured's Name/DOB(if different from patient): _____
Social Security # (last 4 digits only): _____ (Name and DOB exactly as shown on insurance card)

Primary Medical Insurance

- Please provide insurance card(s) to the Front Desk upon your arrival.

IMPORTANT, PLEASE READ: Regarding Insurance: We do not participate in all Vision or Medical plans. It is your responsibility to provide us with your insurance information when you make the appointment. Most insurance companies require pre-authorization. We try to obtain this information prior to your arrival. If you do not provide this information, you are responsible for all fees, deductibles, co-pays and any extras not covered by your insurance. All payments are due at the time of your appointment. We do not bill or mail statements on a regular basis. We accept cash, checks, Visa, MasterCard, Discover and Debit cards.

Signature:_____Date _____

Acknowledgement of Receipt

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Alameda Optometric Group.

_____ _____

Signature Date

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form: