Patient Information

Guarantor/Responsible Person:__________________________________ Date:____/____/____

Patient's Name:____ M_____F_____

First MI Last

Address:____

Street City State Zip

Cell Phone:(____)__________________ SSN#:_____-_____-_____ Patient DOB: ___/___/_____

Home Phone: (____)_______________ Email:_______________________________________

Patient's Spouse's Name:___________________________ Patient's Spouse's DOB:____/____/____

Primary Vision Insurance:_____________________ Primary Insurance ID#:__________________

Primary Insured's Name:_____________________ Primary Insured's DOB:____/____/____

Secondary Vision Insurance:__________________ Secondary Insured ID#:__________________

Secondary Insured's Name:_______________________ Secondary Insured DOB:____/____/____

This office does not guarantee benefits from the insurance company, nor are we responsible for any inaccurate information they give us. Any portion not covered by the insurance company is your responsibility. If at any time your insurance changes it is your responsibility to inform us.

Medical Insurance:________________________________

Primary Care Medical Doctor:___________________________________

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I reviewed or received at my request a copy of Sparta Optometry's Notice of Privacy Practices.

RELEASE OF INFORMATION

I authorized David R Harkema OD, or any other staff to discuss my medical information with:

Name:__________________________________ Relationship:_________________________

Name:__________________________________ Relationship:_________________________

Patient/Legal Rep. Signature:_______________________________________ **Date:**___/___/____