PATIENT INFORMATION FORM

Name_____ Preferred Name_____ M ☐ F ☐
Last First MI

Marital Status Single ☐ Married ☐ Divorced ☐ Other ☐ Email address_____

Race American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Ethnicity Hispanic or Latino yes ☐ no ☐

Mailing Address _____
Street or PO Box City State Zip

Phone (check preferred) _____ ☐ _____ ☐ _____ ☐
Home Work Cell

Patient's SSN _____ Date of Birth _____ Patient's Employer (or School)_____

Person responsible for paying this account _____ Patient's Occupation (or Grade)_____

Name of Last Eye Doctor _____ Name of your Primary Medical Doctor _____

When was your last vision examination? _____

How did you learn of our office?
☐ Located near where I live or work ☐ Our website
☐ Telephone book ☐ Advertising
☐ Internet Search ☐ Referred by _____

Lifetime Authorization Statement / Signature on File Statement / Authorization for release of records for consultation (including via email):
To the best of my knowledge the questions on this form and the Review of Systems Form have been answered accurately. It is my responsibility to inform the doctor's office of changes in my medical status. I authorize Geoff Wills, O.D. and his healthcare staff to access my prior vision and medical records and to perform the necessary services I may require. I authorize the release of any medical or other information necessary to process insurance claims, and authorize payment of medical insurance benefits for services furnished me be made directly to Dr. Wills.

☐ _____ I authorize the release of my medical information, including via email, solely for purposes of medical consultation by other physicians.
Initials

_____ Date _____
Signature of Patient (or Parent/Guardian)

Beneficiary Statement (Medicare Patients only):
I have been notified by my optometric physician that Medicare is likely to deny payment for the services listed below for the reasons stated. I agree to be personally and fully responsible for payment if Medicare denies payment. I understand that, by law, the doctor must bill me for non-covered services.

(x) Medicare pays 80 % of covered services after the deductible is met.
(x) **Medicare does not pay for a refraction** (determination of your glasses prescription)
(x) Medicare does not pay for frames or lenses, except in some cases following cataract surgery.

_____ Date _____
Signature of Patient (or Parent/Guardian)

Notice of Privacy Practices – Statement of Receipt and Consent
I acknowledge that I have received the Notice of Privacy Practices from the office of Geoff Wills, O.D. I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations.

_____ Date _____
Signature of Patient (or Parent/Guardian)
If signing as a personal representative of the patient: Print Name: _____ Relationship: _____

Source of Authority: _____