

Patient's Last Name _____ First Name _____

Responsible Party (if minor) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's Date of Birth ____/____/____ Age _____ Social Security# ____/____/____

Male ___ Female ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Required: Race: _____ Language: _____
Ethnicity: Not Hispanic ___ Hispanic ___ Native Hawaiian/Other Pacific Island ___

Occupation _____ Employer _____ E-Mail _____

By providing your e-mail address you are giving Oswego Vision, Ltd. permission to send you e-mail notifications

COMMUNICATION PREFERENCE: PHONE ___ POSTAL ___ E-MAIL ___

Insurance Information: A medical insurance card must be presented at time of service
Medical Insurance _____ Vision Insurance _____
Insured Name _____ Date of Birth ____/____/____ Social Security # ____/____/____
WE WILL NO LONGER BE ABLE TO PROCESS ANY INSURANCE AND/OR DISCOUNTS
AT A LATER DATE THAN THE ACTUAL DATE OF SERVICE

Your Health Information:

Do You Smoke? ___ Yes ___ No ___ Occasionally

Primary care physician's name _____ City _____

List of medications _____

Are you allergic to any medications? If yes, Please list. _____

Table with 4 columns: Medical History (check all that apply), Patient, Family, I Currently Wear:
Rows include: High blood pressure, Diabetes, Heart problems, Lung problems, Thyroid problems, Medical allergy, Seasonal allergy, Other, Eye History (check all that apply), Injury, Surgery, Cataracts, Glaucoma, Lazy eye, Retina problems, Macular degeneration.

Release of Information: You may release any/and all information to the following family members:
Name/Relationship: _____

Insurance Verification: Insurance must be presented at time of service. Insurance coverage is the patient's responsibility. You are financially responsible for all services and product charges; should your insurance consider any of these charges to be non-covered expenses. For any services other than routine eye coverage, we will bill your major medical insurance company. We do not bill secondary insurances, therefore if for any reason the claim is denied, or applied to your deductible, you are responsible for payment in full. Insurance is not a guarantee of payment. Any and all refunds are processed at the end of each month. We will no longer be able to process any insurance and/or discounts at a later date than the actual date of service.

Responsibility Statement/Acknowledgment of Privacy Practices This form permits our office to computer generate, electronically file and/or personally file any and all claims pertaining to any insurance claim. I, the patient, and/or responsible party, give permission to Oswego Vision, Ltd., to release any information necessary to file for my insurance. I am fully aware that neither confidential information, nor any other information not routinely needed to filing my insurance will be released. I acknowledge and have been made aware that, Oswego Vision, Ltd. has a Notice of Privacy Practices, a copy which has been offered for inspection.

Signature _____ Date _____

Relationship to patient _____