

Welcome to Our Office Returning Patient

Appointment Date _____

There have been changes to my health since my last visit. Yes No (Please Circle)

Patient's Name: _____ Date of Birth: _____ Sex: F M

Last 4 of Social Security # _____

If a Child, Parent's Name: _____ Parent's DOB: _____

Primary Insured Information:

Name: _____ DOB: _____ Last 4 SS# _____

Employer _____

Vision Insurance Co: _____ ID: _____ Group # _____

Medical Insurance Co.: _____ ID: _____ Group # _____

Please complete only if there is a change:

Street Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Spouse's Employer _____

- I wear glasses WEAR/BRING TO APPOINTMENT**
- I am a current contact lens wearer. WEAR CONTACTS TO APPOINTMENT**
- I am interested in discussing wearing contact lenses as a new wearer.**

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- *To the best of my knowledge all information on this form and all verbal information given is correct.*
 - *I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I also acknowledge that a complete Notice of Privacy Policy for this practice is available upon request.*
 - *Explanation of benefits is given as a courtesy to our patients, but is not a guarantee of coverage, benefits, or payment. I understand that I am financially responsible for all charges whether or not paid by insurance. If payment to this account becomes delinquent the account will be assigned to a collection agency.*
 - *There is a \$25 fee for all returned checks.*

Signature of patient (or guardian if patient is a minor) _____ Date _____

Relationship to Patient if patient is a minor _____

Patient Consent for Use and Disclosure of Protected Health Information

Thurman Edward Wood, OD
4819 Calloway Drive Suite 101
Bakersfield, CA 93312
(661)325-7738

I hereby give my consent for Thurman Edward Wood, OD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Thurman Edward Wood, OD describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Thurman Edward Wood, OD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Pennie Wood
4819 Calloway Drive Suite 101
Bakersfield, CA 93312

With this consent Thurman Edward Wood, OD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Thurman Edward Wood, OD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Thurman Edward Wood, OD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Thurman Edward Wood, OD restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Thurman Edward Wood, OD to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Thurman Edward Wood, OD may decline to provide treatment to me.

Patient/guardian must be provided with a signed copy of this authorization form.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Print Patient's Name

Print Name of Guardian if Applicable