

# Welcome to Our Office

Appointment Date \_\_\_\_\_ Which doctor will you be seeing today? Dr. Wood Dr. Graziano

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: F M

Last 4 of Social Security # \_\_\_\_\_ Last 4 of Social Security # of Primary Insured: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Employer \_\_\_\_\_ Parent or Spouse's Employer \_\_\_\_\_

Primary Insured Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

If a minor, Parent's Name: \_\_\_\_\_ Parent's DOB: \_\_\_\_\_

If a returning patient, have there been changes to your health since your last visit? YES NO

- I wear glasses
- I am a current contact lens wearer.
- I am not a current contact lens wearer, but am interested in discussing contacts with the doctor.
- I am interested in corrective refractive surgery.

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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.*
  - *There is a fee for missed appointments not canceled within 24 hours.*

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. A complete copy of The Notice of Privacy Practices document is available and describes these uses and disclosures in detail. I acknowledged that I have been offered the Notice of Privacy Practices.

Signature of Patient (or guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient if patient is a minor \_\_\_\_\_

