**Welcome to West Bend Optical**

**Date:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Gender:** □Male □Female **Marital Status:** □Single □Married □Divorced □Widowed

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 street city state zip code

**Primary Phone#:** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Occupation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Full time employed □Part time employed □Not employed □Student □Retired □Disabled

**Primary Care Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Clinic:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you wear glasses?** □Yes □No

**Do you wear contacts?** □Yes □No If yes, what brand of contacts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Vision Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person Responsible for Account:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured's Date of Birth:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Insured's last four numbers of social security number:\_\_\_\_\_\_\_\_

Medical Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person Responsible for Account:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured's Date of Birth:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Financially Responsible Party**

  *I, the undersigned certify that I (or my dependent) have insurance coverage with the previously stated insurance company and assign directly to Dr. Jerry A. Olson/West Bend Optical. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.*

 *I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released for the purpose of health care operations (including, but not limited to, treatment and payment). I also understand that I may revoke this consent by written request, at anytime, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation, was made with my consent. For additional information on your insurance company’s patient confidentiality policy, please refer to the office insurance administrator for addresses or websites.*

 *I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may restrict insurance payment to the doctor, in which case I am responsible for charges.*

 *I understand the above and I authorize the use of this signature for all insurance submissions.*

 **Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_