jp
Southglenn Eyecare
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Jon F. Pederson, OD

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Last name: _____ First name:_____ MI: __ Today's Date:_____/_____/_____

What would you like to be called: _____ Male ❑ Female ❑

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Birth Date: _____/_____/_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Email: _____ Communication Preference: Email ❑ Postal ❑ Telephone ❑

Married ❑ Single ❑ Widowed ❑ Divorced ❑ Spouse's Name: _____

Race: Native American ❑ Hispanic/Latino ❑ African American ❑ Pacific Islander ❑ Asian ❑ White ❑

Ethnicity: Hispanic/Latino ❑ Pacific Islander ❑ White ❑ Preferred Language: English ❑ Spanish ❑

Occupation: _____ Full Time ❑ Part Time ❑ Retired ❑ Not Employed ❑

Employer: _____ Work Phone: (_____) _____

Whom may we thank for referring you to our office? _____

List of any family members who have been seen in our office: _____

Vision/Eye Insurance:

Insurance Company: _____ Responsible Party's Name: _____

SSN: _____ Birth Date: _____/_____/_____ Phone: (_____) _____

Responsible Party's Employer: _____ Relation to Insured: _____

Medical Insurance (Please present copy of card):

Insurance Company: _____ Responsible Party's Name: _____

SSN: _____ Birth Date: _____/_____/_____ Phone: (_____) _____

Responsible Party's Employer: _____ Relation to Insured: _____

ACKNOWLEDGEMENT OF RECEIPT/ SIGNATURE AUTHORIZATION

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices and I understand how my personal information may be used. I request that insurance benefits be made on my behalf to Southglenn Eyecare for any services furnished to me. I understand that I must pay for any services not completely covered by insurance and/or for services for which I am determined to be ineligible.

Signature of Patient (or Responsible Party) _____ Date: _____/_____/_____