WELCOME TO SANTEE FAMILY OPTOMETRY

Mr.† Mrs. Ms. Dr. Child Date: ___/___/___

Name: _____
Last First Middle

Birth Date: ____/____/____ Age: _____ Sex: † Male † Female

Address: _____
Street, Apt # City, State Zip

Phone: Home (_____)_____
Cell (_____)_____ E-Mail _____

How did you hear about us?

† Friend† Family† Internet† Insurance† Dr. Referral† Walk-In † Other_____

****PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED****

Responsible Payer: _____Relationship to Patient_____

INSURANCE INFORMATION

Name of Insurance _____

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____

I authorize payment of medical benefits to Santee Family Optometry, Inc. I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or coinsurance and that payment for these services is expected on the day the service is rendered.

Initals _____

Due to the Health Insurance Portability and Accountability Act (HIPAA), we are obligated by law to give you notice of our privacy practices. I acknowledge that I read and understand Santee Family Optometry Inc.'s Notice of Privacy Practices, and will be given a copy per my request.

Initals _____

Patient/Guardian Signature _____
Date ____/____/____