Oskaloosa Vision Center Inc Patient Information Sheet

All information is confidential

Patient Information:

Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

City, ST. Zip: _____ **Cell Phone:** _____

Social Security #: _____/_____/_____ **Gender:** ____ **Marital Status:** _____

Employer/School: _____ **Birth Date:** _____

Race: _____ **Ethnicity:**_____ **Language:** _____

Billing Information (only complete if "bill to" is other than yourself)

Bill To:_____ **Home Phone:** (____)_____

Address: _____ **Work Phone:** (____)_____

City, ST. Zip: _____ **Employer:**_____

Relationship to Patient: **Spouse** **Parent** **Other**

Other family members associated with account: _____

Emergency Contact & Other Family Members information:

In case of emergency contact name: _____

Phone #: _____ **Relationship:** _____

Insurance Information:

Insured Name: _____ **Date of Birth:** _____

Address: _____ **Employer:** _____

1. Insurance Company: _____ **Relationship to Insured:**
Self **Spouse** **Child**

2. Insurance Company: _____ **Relationship to Insured:**
Self **Spouse** **Child**

Authorization:

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Oskaloosa Vision Center. I understand that I am responsible for charges not paid by the insurance plan. There will be an administrative fee added to your account if it is referred to Collections.

X _____ **Date:** _____

Privacy Notice Acknowledgement

I acknowledge that the Privacy Notice was made available to me as required by law.

X _____ **Date:** _____