Oskaloosa Vision Center Inc Patient Information Sheet

All information is confidential

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip _____ Work Phone: _____

Social Security #: _____ Gender: _____ Marital Status: _____

Birth Date: _____ Employer/School: _____

Email: _____

Race: _____ Ethnicity: _____ Language: _____

Bill To: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Employer: _____ Relationship to Patient: Spouse Parent Other

In case of emergency contact name: _____

Phone Number: _____ Relationship: _____

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: _____