Welcome to A+ Vision Optometry!

Today's Date: _____

SECTION 1: PATIENT INFORMATION

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ Gender ☐ *Female* ☐ *Male*

Home Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Alternate# _____

Email Address _____

☐ Please do not use my email for office communication (e.g., patient portal. Your email is never sold or used for other purposes.

Race

☐ Caucasian/White ☐ African American ☐ Asian ☐ American Indian ☐ Hispanic/Latino ☐ Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity

☐ Hispanic ☐ Non-Hispanic

Preferred language if not English

_____

SECTION 2: RESPONSIBLE PARTY/PARENT/GUARANTOR *for patients less than 18 years old*

Relationship to Patient

☐ Self *(skip this section)* ☐ Spouse ☐ Parent ☐ Other _____

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ *Gender* ☐ *Female* ☐ *Male*

Home Address _____ City _____ State _____ Zip _____

☐ Same as Patient's

I authorize A+ Vision Optometry to treat/care for this child under the general supervision of any staff optometrist. This consent is given pursuant to the provisions of section 25.8 of the Civil Code of California.

Signature _____ Date _____

SECTION 3: EMERGENCY CONTACT INFORMATION

Last _____ First _____ Relationship to Patient _____

Preferred Phone _____ *Home* ☐ *Work* ☐ *Cell* ☐

SECTION 4: PRIVACY RIGHTS ACKNOWLEDGEMENT

I have read A+ Vision Optometry Privacy Notice and understand my rights contained therein. By way of my signature, I acknowledge that A+ Vision Optometry has provided me with a policy regarding the use and disclosure of my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. A copy shall be as valid as the original.

Signature _____ Date _____

(continued on back)

SECTION 5: INSURED INFORMATION

Relationship to Patient

☐ Self *(skip this section)* ☐ Spouse ☐ Parent ☐ Other _____

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ *Gender* ☐ *Female* ☐ *Male*

SECTION 6: VISION INSURANCE INFORMATION *(VSP, Eyemed, MES)* Present your insurance card(s) to a team member.

Name of Insurance _____ Name of Insurance _____

Member ID# _____ Member ID# _____

SECTION 7: MEDICAL INSURANCE INFORMATION *(Anthem Blue Cross, Blue Shield, Medicare, and supplemental)*

We do not accept HMO's, Cigna, Kaiser or Medi-Cal/Cal Optima. Present your insurance card(s) to the receptionist.

Name of Insurance _____ Name of Insurance _____

Member ID# _____ Member ID# _____

If the patient is covered by more than one plan, please use the below boxes to list plan(s) type.

Name of Insurance _____ Name of Insurance _____

Member ID# _____ Member ID# _____

SECTION 8: HOW DID YOU HEAR ABOUT US?

How did you hear about us? *Please check all that apply*.

☐ Referred by doctor
☐ Recommended by friend or family
☐ Online Search
☐ Online Ad
☐ Social Media Ad: Facebook
☐ Social Media Ad: Instagram
☐ Other _____

AVision OPTOMETRY