GUNDERSON EYECARE

Patient Information **Date:** _____

Personal Information

Full Name: _____ / _____ / _____
Last *First* *M.I.*

Address: _____
Street Address *Apt./Unit #*

_____
City *State* *ZIP Code*

Birth Date: _____ Social Security/Government ID: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____

Who is your employer? _____ Job title/ Grade: _____

Marital Status: (*Please Circle One)* *Single* Married Divorced Widowed Other

Spouse's Name: _____
Guardian/ Guardian/
Spouse's Employer: _____ Spouse's Work #: _____

Family Physician: _____

Who can we thank for referring you? _____

The following 3 questions required for Federal reporting purposes only:

Race: ___African American ___Alaskan Native ___American Indian ___Asian
___Pacific Islander ___White ___ Other

Ethnicity: ___Hispanic or Latino Origin ___Not of Hispanic or Latino Origin

Language: ___Chinese ___English ___Korean ___Other ___Spanish
___Tagalog ___Vietnamese

Insurance Policy Holder Information

Last name_____ First name_____ MI____

Birthday ____/____/_____ Social Security Number: _____

Employer: _____

Secondary

Last name_____ First name_____ MI____

Birthday ____/____/_____ Social Security Number: _____

Employer: _____

GUNDERSON EYECARE

I give Gunderson Eyecare permission to bill my insurance company and to release any pertinent information that is needed to process my claim.

Signed_____ Date _____

Medical Information and HIPAA Release

Release of Information

[ ] I authorize Gunderson Eyecare to release information including the diagnosis, examination findings, and details pertaining to insurance claims to the following individuals:

[ ] Spouse: _____

[ ] Children: _____

[ ] Parents: _____

[ ] Other: _____

I authorize Gunderson Eyecare to contact the individual(s) listed above to convey any pertinent information to me, in the event I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying **Gunderson Eyecare** in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

[ ] Information is not to be released to anyone

Messages:

Please list your following preference of communication

1. [ ] call or [ ] text cell phone [ ] home [ ] work [ ] email
2. [ ] call or [ ] text cell phone [ ] home [ ] work [ ] email
3. [ ] call or [ ] text cell phone [ ] home [ ] work [ ] email

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The Best time to reach me is (day)_____ between(time)_____

Signed: _____ Date: ____/ ____/ ____Witness initials ____

Gunderson Eyecare P.C.
3650 N Newton St
Jasper, IN 47546