



**WELCOME TO OUR OFFICE**

In order to serve you properly we will need the following information.  
All information will be strictly confidential.  
Please print and complete all items fully.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Sex: Male / Female Marital Status: Married / Single / Widowed / Divorced  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year) Ethnicity/Race: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer / School: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Driver's License # / State: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
If patient is a minor, parent or guardian name(s): \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Vision Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
2<sup>nd</sup> Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**St. Lucy's Office Policies**

I have read and understand the office policies of St. Lucy's Vision Center. Please Initial: \_\_\_\_\_

**Medicare / Insurance Release**

I authorize this office to release any information necessary to expedite insurance claims. I authorize use of signatures on this form for insurance claim submissions. I authorize payment directly to my doctor. I understand that I am responsible for all charges, regardless of insurance coverage. All accounts past 60 days are subject to 1 1/2 % finance charge – annual rate 18%.

Patient, Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month/day/year)

**HIPAA Compliance Acknowledgement of Receipt**

I acknowledge that I received a copy of William H. Stephen, O.D. Notice of Privacy Practices.

Allow access to all patient records and information to: (none or full name/relationship) \_\_\_\_\_

Patient, Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month/day/year)