PRECISION EYECARE

Patient Information

Name____Date______________________
Age_______Birth Date______________M/F____ Social Security #_________________________
Race: American Indian____Asian____Black/AA_____Hispanic____Pacific Islander____White___
Mailing Address________________________________City___________State____Zip_________
Phone (home)__________________ (cell) ___________________(work)____________________
Email address____
Emergency Contact______________Emergency Phone______________Relationship___________

Change of Address____

How did you first hear about our practice?

___Friend ___Family member ___Google ____Yelp ___Phonebook
___Facebook ___Insurance Plan ___Another Doctor ____Passing By ___Other

Whom may we thank for telling you about our practice?__________________________________

Acknowledgement of Notice of Privacy Practices

I have read or had explained to me prior to any services offered, Precision Eyecare's Notice of Privacy Practice and agree to continue my care with Precision Eyecare under said terms. I am signing it voluntarily.

Signature of patient or guardian________________________________Date___________

Insurance Information and Signature

Provider: Eric Porisch, O.D. 605 Saint Joseph Street Rapid City, SD 57701

We are happy to utilize your medical and/or vision benefits. If you are not eligible for these benefits, or are eligible for less than full coverage, your signature below indicates that you agree to be financially responsible for any balance that is not paid by your plan.

I authorize payment of medical benefits to myself or the named provider for professional services rendered. I authorize the release of any medical or other information necessary to process this claim.

Signature of patient or guardian______________________________Date____________

Insurance Subscriber's Name___________________________________Male/Female____________
Subscriber's Date of Birth_____________________Social Security #_________________________
Address if different than patient____
Insurance Co.________________________Group #__________________ID#_________________
Insurance Address____
Insurance Phone #____
Relationship to patient: ___self ___spouse ___parent/guardian

Exam fees are payable to Precision Eyecare upon completion of eye exam.