

Welcome to Eye Associates

Dr. Vaughn D. Parfitt • Dr. Kara Jo Dodgens

www.andersonoptometry.com

Patient Information

Name: _____ Date: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Where do you prefer to receive phone calls? Home Work Cell

Married Widowed Single Minor Separated Divorced

Employer/School _____ Occupation _____

Spouse or Parent's Name _____ Employer: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone: _____

Relationship to you? _____

E-mail Address: _____

May we contact you by e-mail with appointment reminders, office information, newsletters, and other information?

Yes No

Insurance Information:

Primary

Secondary

Insurance Company: _____

Policy Holder's Name: _____

Telephone: _____

Relation to Patient: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Certification and Assignment

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr. Kara Jo Dodgens and Dr. Vaughn D. Parfitt all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date