Newberg Vision Clinic

PATIENT INFORMATION FORM

First name		Last name				Middle initial	
Nickname		Gender		Age		Last 4 of SSN	
Date of Birth		Preferred Language					
Address		City		State		Zip	
Home Phone			Work Phone				
Cell Phone			Email				
Employer							
Primary Care Provider		Phone		Fax			

Race/Ethnicity—please mark up to two choices for race and one choice for ethnicity

Race		White		Asian		Black or African American		American Indian or Alaska Native	
		Native Hawaiian or other Pacific Islander							
Ethnicity		Not Hispanic or Latino				Hispanic or Latino			

Insurance information (patients must provide insurance card prior to exam, we offer insurance/billing coordination as a courtesy to our patients.)

	Subscriber Name	Relationship to subscriber	Subscriber DOB	Insurance ID#
Vision Carrier				
Medical Carrier				

Responsible Party Billing Information

	Check this box if your billing information is the same as the above				
Name					
Street					
City		State		Zip	
Home Phone		Work Phone			
Cell Phone		Email			

Individuals with whom we may share medical information (spouse, children, parents, caregivers, etc.) Please mark the EC box if they are an emergency contact.				EC
Name		Phone		
Name		Phone		
Name		Phone		

Notice of Privacy Practices: I acknowledge by my signature below that I have been given the opportunity to review the Notice of Privacy Practices for Newberg Vision Clinic (NVC) and I understand that I may request a copy of this notice should I so choose.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to the physician or supplier for services rendered.

I agree to pay any extra charge that is over and above the allowable paid by my insurance company. I also agree that I am financially responsible for payment if the insurance company denies the claim.

Patient or Guardian Signature _____Date _____