# Welcome To Our Office

In the course of providing service to your, we create, receive and store health infromation that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by?

**PRIMARY INSURANCE INFORMATION**

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

**Patient Relationship to Insured**

☐ Self ☐ Spouse ☐ Child ☐ Other

**Patient Status**

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

**SECONDARY INSURANCE INFORMATION**

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

**Patient Relationship to Insured**

Insured's Identification Number | Group Number | Insured's Date of Birth ☐ Self ☐ Spouse ☐ Child ☐ Other

**Please Read:**

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our sevices or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.
You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and helath care operations.
I acknowledge that I have received and/or read the *Notice of Privacy Practices* form College Point Optometric Associates .

Signature | Date