

Schlaefer Optometrists

Welcome To



Patient Information FULL Name: Date of Birth: Address: Patient SS#: Citv: **Primary** Phone: Home
Cell State: **Secondary** Phone: Home
Cell Zip Code: Work Phone: Email Address: Employer: **EMERGENCY Contact Name: Emergency Contact's Phone:** Schlaefer Optometrists Notice of Privacy Act and Assignment and Release I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I acknowledge that on the date signed below I have been explained by Schlaefer Optometrists their Notice of Privacy Practice. At this time, I was given the opportunity to take a copy home or may request a copy anytime in the future. Date: Signature: Stop Here Please. Insurance Information Primary Medical: _____ Primary Vision: Secondary Medical: _____ Secondary Vision:_____ Sign: _____ Date: _____ Date:____ Sign: _____ Date:_____

Sign: ______ Date:_____