

Welcome to Spivack Vision Center

a Madison Street Company®

Proudly Owned by Employees

Please complete this form and return it to the receptionist. The information will be used to prepare your chart.

PERSONAL INFORMATION

Name (Please print) _____ Male [] Female [] Date ____/____/____

Street _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message in regards to your care at your home #? ___ Yes ___ No cell #? ___ Yes ___ No work#? ___ Yes ___ No

Email _____

Age _____ Date of Birth _____ Social Security Number _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____

Name of Nearest Relative not living with you _____

Address _____ Phone _____

Name of current primary care physician: _____

Do you have an eye doctor? ___ Yes ___ No Name of eye doctor _____

Did your eye doctor refer you here? ___ Yes ___ No

How did you hear about Spivack Vision Center? Please indicate who we can thank for your visit. (Please Choose One)

_____ Doctor _____ Co-Worker _____

_____ Family _____ TV Station _____

_____ Friend _____ Newspaper _____

_____ Radio Station _____ Other _____

_____ Internet Website _____

REASON FOR VISIT

_____ Emergency, Medical Concern _____ LASIK Evaluation _____ Surgery Pre-op Exam

_____ Physician Suggested Exam _____ Eye Irritation _____ Desire Second Opinion

Please explain briefly the reason for your visit: _____

INSURANCE:

Name of Primary Insurance Company _____ HMO _____ PPO _____

Subscriber Name (if other than yourself) _____

Subscriber's Social Security Number _____ Relationship to you _____

Subscriber's Date of Birth _____

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- I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatment performed at Spivack Vision Center considered necessary or advisable by the attending physician.
 - I authorize Spivack Vision Center to file any claims for payment of patient bills and assign all rights and benefits to Spivack Vision Center as appropriate. Except as prohibited by any agreement between my insurance company and Spivack Vision Center or by state and federal law, I agree to be responsible for co-payments, deductibles, or other charges for medical services not covered or paid by insurance or third party payors. I hereby authorize said assignees to release appropriate information to secure payment. I agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event that Spivack Vision Center has to take action to collect the same because of my failure to pay incurred charges.
 - I acknowledge the receipt of Spivack Vision Center's notice of health information practices, which describes how my health information can be used or disclosed and to whom.

I have read the above statement and by signing this form I understand and agree to what it states.

Signed: _____ Date: _____