WELCOME TO HUDSONVILLE VISION CARE

PATIENT INFORMATION

Date: _____ Referred By: _____

Legal Name:	Birthdate: Sex: Male Female
Address:	Marital Status: Single Married Divorced Widowed
City: State: Michigan Zip:	Cell Phone:
Home Phone:	Work Phone:
Student: Full Time or Part Time School Name:	Employer: Full Time or Part Time

RESPONSIBLE PARTY – IF OTHER THAN ABOVE

Name: Relationship to Patient:	Birthdate:
Address:	City: State: Michigan Zip:
Home Phone:	Work Phone:
Cell Phone:	Employer Name:

EMERGENCY CONTACT

Name:	Relationship:
Home Phone:	Work Phone:

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Name of Ins Co:	Name of Ins Co:
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Birthdate of Insured:	Birthdate of Insured:
Social Security #: Or ID #:	Social Security #: Or ID #:
Employer of Insured:	Employer of Insured:

I have accurately answered the above questions to the best of my knowledge. I authorize Hudsonville Vision Care to use or release any information, including the diagnosis and the records of any treatment or examination given to me or my child, to third party payers and/or health practitioners. (Our Privacy Practice describes in more detail how we handle such uses and disclosures.) I understand that I will be responsible for charges not covered by the Insurance Company. I do authorize payment to be made directly to Hudsonville Vision Care.

_____ _____

Signature of Patient or the Parent/Legal Guardian of a Minor Date

Patient's Annual Review of Information: ____/_____, ____/_____, ____/_____

Initial Date Initial Date Initial Date