



Welcome

Date: _____

"If your eyes are good, your whole body will be full of light." – Matt 6:22

Patient Information

Thank you for choosing our practice for your vision care needs. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Last Name: _____ First: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone #: _____ Cell #: _____ Work #: _____

Social Security #: _____ Birthdate: _____

Email: _____ Sex: M F

Vision Insurance: VSP Eyemed Other (please complete below) None

Plan Name: _____ Member ID#: _____

Member Name: _____ Member Birth Date: _____

I authorize the release of any medical or other information necessary for the purpose of evaluating and administering claims for insurance benefits (see Notice of Privacy Practices). I also hereby authorize payment of insurance benefits directly to Shafer Vision Care, P.C. for services performed at this practice. The patient is responsible for payment of any service not covered by insurance.

X _____ Date _____
Signature of patient or authorized person

HIPPA Acknowledgement

I acknowledge that I have received a copy of Dr. Melissa Shafer's Notice of Privacy Practices.

X _____ Date _____
Signature of patient or authorized person

Responsible Party

Same as above Shown below

Relationship to Patient: _____ Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Your Medical information is personal to you and by law we are required to keep it private. On occasion, a family member, friend, or caregiver may contact Shafer Vision Care, P.C. to inquire about your medical information. Please list those individuals to whom the information may be disclosed.

How did you hear about us?

- Mailing
 - Insurance Provider
 - Vision Shaping Therapy
 - Yellow Pages
 - I-74 Billboard
 - Drove by
 - Website / Internet
 - Referral
 - Other
- Who: _____
please explain: _____

Thank you!