UTAH VALLEY VISION CARE

Dr Traer G Caywood, Dr Timothy J Seiter, & Dr Paige T Brown

Personal Information – Please Print Clearly

Last Name:________________________ First Name_________________________ MI _____ Today's Date: ________/________/________

Address:____ Date of Birth: ________/________/________

City____________________ State _____________ Zip__________ Gender: ☐ Male ☐ Female

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Preferred Name: _______________________

Marital Status: ☐ Married ☐ Single ☐ Other Preferred Language:_______________ SS#:_________________________________

Employment Status: ☐ Retired ☐ Employed ☐ Full-time student ☐ Part-time student ☐ Minor ☐ Homemaker

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Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander ☐ White or Caucasian

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Personal Health Info Release: I authorize the following to receive any medical documents or materials on my behalf

Primary: _____________________________ Secondary: _____________________________ Tertiary: _______________________________

Contact Information: (By including your email, you agree to receive appointment reminders, newsletters, social media, and promotions from our office.)

Home Phone: ____ Work Phone: __________________________________ Ext.__________

Cell Phone: ____ Email: ____

Preferred method of contact: ☐ phone ☐ work ☐ cell ☐ text ☐ email

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Please tell us how you were referred to our office: ☐ Insurance Panel ☐ Phonebook ☐ Website ☐ Daily Universe ☐ Facebook ☐ School ☐ Internet Search ☐ Doctor's Clinic________________________ ☐ Individual: _____________________

Relationship Information/Policy Holder:

Responsible Person: ____ Patient's Relationship to Person: ☐Self ☐Spouse ☐Child

Address: ____ Date of Birth: _____/_____/_____

City_______________ State________________ Zip ___________ Phone #: _____________________

Emergency Contact: ______________________________________ Emergency Phone: ____

Medical Doctor: ____ City: ___________________ Last Medical Exam: _____/_____/_____

Insurance Information:

Primary Insurance: _____________________________________ Secondary Insurance: ___________________________________

Policy Holder: ____ Policy Holder: ____

Policy/SS#: ____ Policy/SS#: ____

Employer of Insured: ___________________________________ Employer of Insured: ____________________________________

Please Read and Sign Below:

Payment for all medical services is the responsibility of the patient and is expected at the time of service.

I agree to pay all attorney fees, court costs, and filing fees, including charges or commissions up to 50% that may be assessed to me by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of one and one half percent per month (18% per year). I understand there is a $25.00 service charge for all returned checks.

I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to provider of facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be released to anyone else without my written consent.

I hereby authorize any procedures, including dilation of the eyes, as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.

Acknowledgement of Receipt:

I acknowledge that I received the following policies from the office of Drs. Caywood, Seiter, & Brown:

☐ **Notice of Privacy Practice** ☐ **Financial Responsibility Information** ☐ **Understanding Insurance**

X____ X___________________________________ X ___________________

Signature of patient or legal guardian Print Name Today's Date

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For office Use only: ☐ Dr. TC ☐ Dr. TS ☐ Dr. PB ☐ uploaded pt doc pg