

Exam Date:     /     /

Patient Information

Loveland Eyecare, LLC

**The Patient**

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other

Marital Status : ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name \_\_\_\_\_  
Last First Middle Initial Nickname

Address \_\_\_\_\_  
Street Town State ZIP

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone \_\_\_\_\_  
Home Cell Work Email

Primary Care Physician \_\_\_\_\_  
Name Phone City, State

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employment Status: ☐ Full time ☐ Part time ☐ Not employed ☐ Self Employed ☐ Full time Student ☐ Part time Student

☐ I have no medical or vision insurance

How did you hear about us? \_\_\_\_\_

Medical Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Vision Insurance \_\_\_\_\_ ID# \_\_\_\_\_

**The Insured**

☐ Same as above

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street Town State ZIP

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone \_\_\_\_\_  
Home Cell Work Email

**Acknowledgement**

Please be advised that as a participating provider with your insurance carrier, we will submit the appropriate claim for your vision benefits. However, payment from the insurance company is dependent upon eligibility as determined by your employer at the time of service. Your signature below indicates that you acknowledge the above and agree to pay any outstanding amount that is not covered or paid by your insurance company.

**Signature on File:** I also request that payment of authorized benefits be made on my behalf to Loveland Eyecare, LLC for services furnished to me by the provider.

Patient /Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Acknowledgement of Receipt of Privacy Practices (HIPPA)**

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Authorization** If you would like to authorize Loveland Eyecare, LLC to disclose your protected health information (copy of your records & prescription, discussion of condition with Dr. Loveland, etc.) to a family member, please complete the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ (You have the right to cancel this authorization, in writing, at any time.) I understand this authorization is valid for 1 year. **Your Initials:** \_\_\_\_\_