Dr. Traer Caywood, Dr. Rick Winward & Dr. Tim Seiter
Utah Valley Optometric Physicians, LLC

Personal Information – Please Print Clearly

Last Name:_____ First Name_____ MI _____ Today's Date: _____/_____/_____

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

_____ Gender: □ Male □ Female

City State Zip

Prefix: □ Mr. □ Mrs. □ Ms. □ Dr. Preferred Name: _____

Marital Status: □ Married □ Single □ Other SS#:_____

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

Race/Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic
□ Native Hawaiian or other Pacific Islander □ White or Caucasian Preferred Language: _____

Contact Information

Home Phone: _____ Work Phone: _____ Ext._____

Cell Phone: _____ Email: _____

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

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: _____/_____/_____

_____ Phone #: _____

City State Zip

Employer: _____ Address:_____ City_____ 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, Winward ,and Seiter:

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

X_____ X_____ X _____

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

For office Use only: □ Dr. TC □ Dr. RW □ Dr. TS □ uploaded pt doc pg