Patient Information

Date _____

Name _____ ☐Male ☐ Female
First MI Last

Address _____City _____State _____ Zip _____

Birthdate: _____ SSN: _____ ☐married ☐single ☐ divorced ☐widowed

Occupation: _____ Employer: _____

Preferred-contact#:_____Other#:_____Email: _____

Emergency Contact: _____ Relationship to Patient: _____Phone#: _____

Spouse or parent/guardian name: _____ Employer: _____ Work#:_____

Whom may we thank for referring you to our office? _____

Responsible Party

Who is responsible for this account? _____ Relationship to Patient:_____

Birthdate: _____ SSN: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact #: _____ Otherl #: _____

There will be a $20 service charge for all returned checks.
I agree to be responsible for all payments on my behalf or on behalf of my dependents.

Signature _____ Date: _____

Insurance Information

Primary Ins Company_____ Member ID #: _____Group #:_____

Name of Policyholder: _____ _____Relationship to Patient: _____SSN#_____

Birthdate: _____ Address: _____ City:_____ State: _____Zip: _____

Secondary Ins Company_____Member ID #: _____Group #:_____

Name of Policyholder: _____ _____Relationship to Patient: _____SSN#_____

Birthdate: _____ Address: _____ City:_____ State: _____Zip: _____

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with the company listed above on the date of service, and assign directly to Streeter Vision Inc or its team of doctors, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges ***whether or not paid*** by insurance. In the event my insurance company denies payment for goods or services received from Streeter Vision Inc, I agree to pay the balance in full. I authorize the use of my signature for all insurance submissions on my behalf.
HIPPA Privacy Statement: By signing below, I also certify that I have been offered a copy of the current HIPPA privacy regulations that govern this office. I am aware that these guidelines are posted in the office for my reference.

Signature of patient/guardian_____ Date_____relationship to patient _____