Patient Information

Date ___________________

Name ____ ☐Male ☐ Female

First MI Last

Address ________________________________City _______________State ______ Zip ___________

Birthdate: _________________ SSN: _____________________ ☐married ☐single

Occupation: ________________________ Employer: _________________________

Preferred-contact#:__________________________Other#:________________________Email: ______________________________

Emergency Contact: ___________________ Relationship to Patient: __________________Phone#: ___________________________

Spouse or parent/guardian name: _______________________________ Employer: _________________ Work#:_________________

Email address: (used for appt reminders and eyeglass notifications only): ____

Responsible Party

Who is responsible for this account? ___________________________________ Relationship to Patient:_________________________

Birthdate: ____________________ SSN: _______________________________ Employer: _________________________________

Address: _______________________________ City: _____________________ State: ________ Zip: _________________________

Preferred Contact #: _______________________________ Other #: ___________________________

There will be a $20 service charge for all returned checks. These are fees assessed by the bank.
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.
HIPAA 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 ____________