



Dr. Gerhardt



Dr. Jennings



Dr. McManis



Dr. Ruhl

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date: _____

Patient Name: _____ Home Phone: _____

Address: _____ State: _____ Zip: _____

SSN: _____ Male Female Birthdate: _____

Check the appropriate box: Minor Single Married Divorced Widowed Separated

Patient's or parents employer: _____ Work Phone: _____

Business Address: _____ City/State: _____

If patient is a student, name of school/college: _____ City/State: _____ Zip: _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to the patient: _____

Address: _____ Home Phone: _____

Birthdate: _____ Financial institution: _____

Employer: _____ Work Phone: _____

Is this person currently a patient of our office? Yes No (Full payment is due and expected the day services are rendered for discounts)

Insurance Information

<p>Vision Insurance <input type="checkbox"/> None</p> <p><input type="checkbox"/> EyeMed <input type="checkbox"/> VSP <input type="checkbox"/> Farm Bureau</p> <p><input type="checkbox"/> Vision One <input type="checkbox"/> Davis <input type="checkbox"/> Coast to Coast</p> <p>Insurance Co.: _____ Group #: _____</p> <p>Address: _____</p> <p>Employer: _____ Work Phone: _____</p> <p>Name of insured: _____ Relationship: _____</p> <p>DOB: _____ SSN: _____ Date employed: _____</p> <p>Deductible? Yes No Amount: _____</p>	<p>Medical Insurance <input type="checkbox"/> None</p> <p>Medicare #: _____</p> <p>BC/BS (Wellmark) #: _____</p> <p>Iowa Title 19 #: _____</p> <p>Insurance Co.: _____ Group #: _____</p> <p>Address: _____</p> <p>Employer: _____ Work Phone: _____</p> <p>Name of insured: _____ Relationship: _____</p> <p>DOB: _____ SSN: _____ Date employed: _____</p> <p>Deductible? Yes No Amount: _____</p>
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HIPPA Authorization & Release of Medical Information

I authorize release of any information concerning myself, or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the doctor(s) today and in the future.

I acknowledge that I was offered/received a copy of American Eyecare's Notice of Privacy Practices. (If patient is under guardianship, legal guardian should sign as well).

Signature of patient or parent/guardian if a minor. _____ Date. _____

Family members at home Age

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If we can do anything special for you, Please ask!

