DRS. ROUSH & WILL OPTOMETRISTS, INC.

PATIENT INFORMATION

Last Name_____**First Name**_____ **MI**_____

Date of Birth_____ **Age**_____ **Sex** __M __F **Social Security** _____ **Marital Status** S M W D Minor

Mailing Address_____City_____ST____ ZIP_____

Preferred mode of communication:__House Phone__ Cell __Work Phone

House Phone (____) _____ Cell (____)_____ E-Mail_____

Ethnicity: _Not Hispanic or Latino _ Hispanic or Latino _ Unknown _ Patient Declined to Answer

Race: _White _American Indian or Alaska Native _Asian _ Black or African American _ Native Hawaiian or other Pacific Islander _Other

Preferred Language: _English _ Spanish _ French _ Other_____

In Case of Emergency (Name, Phone, Relation) _____

Patient Employed By _____**Work Phone (_____)** _____

Spouse's Name _____Date of Birth_____ SS#_____

Spouse's Employer:_____ Employer Phone _____

PARENT/GUARANTOR INFORMATION

Last Name _____First Name _____MI_____

Date of Birth_____ Age: _____ Sex _ M _F SS#_____

Mailing Address_____City_____ST_____ ZIP_____

Home Phone_(____)_____ Cell_(____)_____ Preferred __Home __Cell

Employer _____ **Relation to Patient** _ Parent _Guardian _Spouse _Employer

PRIMARY INSURANCE

Vision □ Medical □

Insurance Carrier_____| Name_____ Sex: M F

Subscriber ID _____| Date of Birth_____Relation_____

Address _____| Address _____

City _____ State ____ Zip _____ | City_____State ____Zip _____

Employer_____ Employer Phone _____

SECONDARY INSURANCE

Vision □ Medical □

Insurance Carrier_____| Name_____Sex: M F

Subscriber ID _____| Date of Birth_____ Relation_____

Address _____| Address _____

City _____ State ____ Zip _____| City_____State ____Zip _____

Employer_____ Employer Phone _____

ASSIGNMENT AND RELEASE

***Assignment of Benefits**: I authorize payment directly to Drs. Roush & Will Optometrists, Inc. for all benefits if any, otherwise payable to me. I also acknowledge that Drs. Roush & Will Optometrists will submit my bill to my current insurance carrier as a courtesy.

I the undersigned understand that I am financially responsible for all charges whether or not paid by insurance.

Release of Medical Records: I authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

*Patient or Responsible Party Signature _____ Date:_____