Welcome to Schlaefer Optometrists

Patient Information

Name:	Date of Birth:
Address:	Patient SS#:
City:	Cell Phone #:
State:	Home Phone #:
Zip Code:	Work Phone #:
Under 18? Yes ☐ No ☐	
Responsible Party:	
Employer:	Email address:
Occupation:	

Schlaefer Optometrists Notice of Privacy Act

I acknowledge that on the date signed below I have been explained by Schlaefer Optometrists their Notice of Privacy Practice. At this time I was given the opportunity to take a copy home or may request a copy anytime in the future.

Signature: Date:

Insurance Information

Primary: _____ Secondary: _____

☐ Medical ☐ Routine ☐ Medical ☐ Routine

FOR OFFICE USE ONLY: Date & Initial

ROI: ☐ _____ ☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____ ☐ _____

Assignment and Release

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: Date: