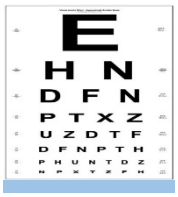

Welcome To
Schlaefer Optometrists

Patient Information	
Name:	Date of Birth:
Address:	Patient SS#:
City:	Primary Phone: Home ☐ Cell ☐
State:	Work Phone:
Zip Code:	Secondary Phone: Home ☐ Cell ☐
Employer:	Email Address:
EMERGENCY CONTACT:	Emergency Contact's Phone:

If you are under age 18:

Your responsible party is: _____

Relationship to patient: _____

Insurance Information	
Primary: _____ Medical	Secondary: _____ Medical

Vision Insurance
Primary Vision: _____

FOR OFFICE USE ONLY: Date and Initial

ROI: 1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Schlaefer Optometrists Notice of Privacy Act and 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 the signature on all insurance submissions.

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:***