Omaha Center for Sight

Patient Information

Name: _____ **DOB**: _____ **Social Security**: _____

Address: _____ **Account #:** _____

City, State, Zip: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Which phone is your preferred method of Contact? ☐ Home ☐ Work ☐ Cell

Email: _____ **Employer:** _____

Primary Care Doctor: _____ **Referring**: _____

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other

Primary Language: _____ **Ethnicity:** ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Insurance Holder (if different from patient)

Name: _____ **DOB**: _____ **Social Security**: _____

Relationship: _____ **Employer:** _____

Address: _____ **Phone**: _____

City, State, Zip: _____

Primary Insurance

Policy Holder: _____

Insurance Co: _____

Policy ID: _____

Group #: _____

Secondary Insurance

Policy Holder: _____

Insurance Co: _____

Policy ID: _____

Group #: _____

Emergency Contacts & Permission to Release Medical information

Name: _____ **Phone**: _____ **Relationship:** _____

Name: _____ **Phone**: _____ **Relationship:** _____

Name: _____ **Phone**: _____ **Relationship:** _____

Name: _____ **Phone**: _____ **Relationship:** _____

I have verified the above information is correct. Patient Initials: _____ Date: _____

Patient acknowledges receipt for HIPPA, Financial and Refraction Policies, Assignment of Benefits and Consent to Treatment. Patient understands that the collection of $75 is a down payment for services and the balance will be billed following their insurances. Self-pay patients are required to make a down payment of $175 at the time of services and the remainder will be billed. Insurance is considered a form of payment and is not guaranteed. Responsibility for payment falls to the patient, should insurance deny.

Patient Signature: _____ Date: _____