Welcome to our office!

Clayton G. Skrzypczak, O.D.

Date: ______________________

Patient name: ____ DOB: ________________ Age: __________

Mailing Address: ____ SSN #: ____________________

City: ____ State: ______________ Zip Code: ______________

Spouse/Parent if under 18 _______________________________ Home Telephone: _________________________

Patient's Occupation: ___________________________________ Cell Telephone: __________________________

e-mail: ____ ***PLEASE CIRCLE PREFERRED CONTACT NUMBER***

Primary Care Doctor: _____________________________________

Preferred Pharmacy: (name/location) ____

Insurance Information: Vision: ___________________________ Medical: ________________________________

Insurance subscriber's name, date of birth & last 4 SS# (if different from patient): (Primary Cardholder)

______ ____

Do you wear Contact Lenses? ❑ Yes ❑ No Are you interested in wearing Contact Lenses? ❑ Yes ❑ No

What type/brand of Contact Lenses do you wear? ____

EYE MEDICATIONS: (Please list all)

Medication Name	Dosage

Eye Vitamins (AREDS, Macular Degen.) ❑ Yes ❑ No Artificial Tears ❑ Yes ❑ No

OTHER MEDICATIONS: (Please list all)

Medication Name	Strength	Dosage

Aspirin? ❑ Yes ❑ No Insulin? ❑ Yes ❑ No Ever used Flomax or other prostate med? ❑ Yes ❑ No

Height: _________________ Weight: _________________ Blood Pressure: _________________

If female, are you currently pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

EFFECTIVE DATE OF NOTICE: May 1, 2015

Dr. Clayton G. Skrzypczak
Kalkaska Family Vision Care
882 M-72 NW
Kalkaska, MI 49646
(231) 258-9781

NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. A copy of our privacy policy is available upon request.

AUTHORIZATION

I authorize the professional office of my optometrist named above to release health information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual billed services. I agree to be responsible for payment of all services rendered on my behalf or myself or my dependents.

FINANCIAL RESPONSIBILITY

Patients who have optical/medical/vision insurance are reminded that charges for optometric services rendered by our office are the responsibility of the patient and not their insurance carrier. Insurance is a contract between the patient and the insurance company. Services rendered by your doctor on your behalf are services provided to you personally and as such, are your responsibility. While we accept and participate in several insurance plans, it is the responsibility of the patient to be aware of what level of service they are eligible for under their plan. We will cheerfully assist you in any reasonable way in contacting your carrier and filing insurance claims on your behalf. Payment is due on the day of service for examinations unless we have an authorization from a plan that our office participates with. Optical orders require a deposit of half down when ordered, with the remainder due when dispensed. Please acknowledge your understanding of these policies by signing on the line below.

Signature: ____ Date: __________________________

Patient (or Parent, if under 18)