EYECARE Associates

Dr. Brian Duvall, O.D. Dr. Rebecca Dale, M.D. Dr. Bryan Redick,O.D.
Dr. Nessa Livingston, O.D. Dr. Nathania Nhouyvanisvong, O.D.

Patient Information:

Last Name **First** **Middle** **Marital Status:**

_____ _____ ☐Single ☐Married

Mailing Address **City** **State** **Zip** ☐Other

_____ **Sex:**

☐Male ☐Female

Birth Date **Age** **Social Security #** **Daytime Phone** **Cell Phone**

_____/_____/_____ _____ _____-_____-_____ (_____)_____-_____ (_____)_____-_____

E-mail Address **Employer** **Occupation**

_____ _____ _____

Referred By: _____

In order to comply with medical insurance, vision plans, and the HiTech Act enacted by the Federal Government, we need the following information for your medical record. Please select one or more options from the following:

Race:

☐ African America ☐Caucasian ☐Other
☐ American Indian ☐Hawaiian/Islander
☐ Asian ☐Hispanic

Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Latino ☐Other

Communication Preference: ☐ E-Mail ☐ Phone ☐ Mail

Preferred Language: _____

Insurance Information: *Please give your insurance card(s) to the front desk!*

Subscriber's Name **Birth Date** **Social Security #**

_____ _____/_____/_____ _____-_____-_____

Subscriber's Address (if different from patients)

_____

Subscriber's Phone # **Subscriber's Employer** **Relationship to Patient:**

(_____)_____-_____ _____ ☐Self ☐Spouse ☐Child ☐Parent/Guardian

In Case of Emergency:

Name of Friend or Relative **Relationship to Patient** **Phone Number**

_____ _____ (_____)_____-_____

HIPAA Notice of Privacy Practices-Acknowledgement

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Snoqualmie Valley Eyecare Associates. **I understand that I am financially responsible for any balance or co-payment**. I also authorize Snoqualmie Valley Eyecare or my insurance company to release any information required to process my claims. We maintain permanent service records of your health care. You may also ask to see and copy your records. We will not disclose your records to others unless you direct us to do so, or as outlines in our **Notice of Privacy Practices**, which describes in detail how your health information may be disclosed. **I have read the Notice of Privacy Practices and agree to them:**

x_____ x_____ _____/_____/_____

Patient/Guardian Signature **Please Print Name** **Date**