

# Welcome to Gillette Optometric Clinic, PC

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please circle preferred Contact Phone: Home / Work / Cell

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer / School: \_\_\_\_\_ Full Time \_\_\_\_\_ / Part Time \_\_\_\_\_

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_ Marital status: S \_ , M \_ , D \_ , W \_

Spouse's Name: \_\_\_\_\_ Spouse's contact phone number: \_\_\_\_\_

Emergency contact name and phone number: \_\_\_\_\_

## GUARANTOR INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guarantor Employer: \_\_\_\_\_ Full Time \_\_\_\_\_ / Part Time \_\_\_\_\_ / Retired \_\_\_\_\_

Please list all family members so we can link them together under one guarantor.

## MEDICAL & VISION INSURANCE

Vision Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Relationship to insured: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Relationship to insured: \_\_\_\_\_

## PLEASE READ, SIGN and DATE

### **Authorization For Benefits and Medical Release and Acknowledgement of Privacy Practice**

*I authorize insurance payments directly to Gillette Optometric Clinic PC. I further authorize the release of any information necessary to process claims on my behalf. I understand that insurance estimates are estimates only and agree that I am financially responsible for all charges incurred by me or any family member regardless of insurance. I acknowledge that I have received a copy of Gillette Optometric Clinic PC Notice of Privacy Practice related to HIPAA.*

It is the patient's responsibility to provide us with the most current insurance information.  
Please be advised that we only file primary insurance.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_