

# Welcome To Our Office

## Waren Optometry

**PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION**

Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Business Phone# \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex:  F  M Cell Phone# \_\_\_\_\_  
Date of Last Exam \_\_\_\_\_ Optometrist's Name \_\_\_\_\_  
Job Title \_\_\_\_\_ Hobbies \_\_\_\_\_ Family Doctor \_\_\_\_\_  
Who may we thank for referring you to us? \_\_\_\_\_

## Insurance

**PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST**

Primary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Employer Group Name \_\_\_\_\_  
Member's Date of Birth \_\_\_\_\_  
Secondary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Employer Group Name \_\_\_\_\_

I understand that by signing this consent form I am allowing my medical information to be released to my insurance company for such purposes as claims payment, provider review and quality assessment. I understand that I may revoke this consent in writing at any time. The revocation cannot apply to previously released information.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date