

WELCOME TO THE OFFICES OF JIM L. DAVIS O.D. AND ASSOCIATES

Please Print

PATIENT INFORMATION: DATE: _____

Patient Name: _____

Address: _____

City/State/Zip: _____

Home Phone: () _____ Mobile Phone: () _____

Work Phone: () _____ Email: _____

Gender: M ___ F ___ Date of Birth: _____ Age: _____ Marital Status: _____

Social Security #: _____ Driver's License #: _____

Employed By: _____ Occupation: _____

Spouse's Name: _____ Work Phone: () _____

Parent or Legal Guardian: _____

Address: _____

City/State/Zip: _____

Home Phone: () _____ Mobile Phone: () _____ Work Phone: () _____

Electronic Health Record Required Questions:

Primary Language: (check one)

() English () Spanish () Other: _____

Race: (check one)

() Caucasian () African American () Asian () Hispanic/Latino () Native American () Other

Ethnicity: (check one)

() Not Hispanic or Latino () Hispanic or Latino Pacific Islander () Unknown

Vitals: Height: ___ft ___in Weight: ___ lbs

INSURANCE INFORMATION

VISION INSURANCE: () No () Yes If yes, name of vision insurance: _____

Insured's Name: _____ Insured's DOB: _____

Insurance ID #: _____ Group #: _____

MEDICAL INSURANCE: () No () Yes If yes, name of vision insurance: _____

Insured's Name: _____ Insured's DOB: _____

Insurance ID #: _____ Group #: _____

Who is responsible for payment if not covered by insurance? _____

Address if different from above: _____

We file all Medicare/Medicaid claims and most other insurance plans; but due to the large number of ins. plans we participate in, knowledge of any special plan requirements or limitations is your responsibility.

ALL PATIENTS MUST READ THE FOLLOWING STATEMENTS AND SIGN BELOW

I, the undersigned, certify that I (or my dependents) have insurance coverage. I assign all payments to Dr. Jim L. Davis and Associates and their doctors for services rendered. I authorize the release of any medical information necessary to process this or any future claims.

By my signature, I acknowledge that I have read and understand the above statements.

Patient Signature: _____

Date: _____

(or responsible party)

HIPAA POLICY

I acknowledge that I have read Dr. Jim L. Davis, O.D. and Associates notice of Privacy Practices (HIPAA Policy) which explains to me how Jim L. Davis, O.D. and Associates handles my protected health information. (Policy attached to clipboard).

Patient Signature: _____

Date: _____

(or responsible party)

The following may have access to my records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____