PATIENT FORM

Dr. Dipak R. Kalani
Dr. Linda S. Haidar
VisionSource-ShadowCreek.com

Name:_____/_____/_____ **Gender:** ☐ Male ☐ Female
Last First MI

Address:_____ **SS #:**_____

City:_____ **State**_____ **Zip:**_____ **DOB:**_____

Cell Phone:_____**Home:**_____ **Occupation:**_____

****E-mail:**_____ **Employer/School:**_____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single ☐ Minor

How did you hear about us (Source): ☐ GOOGLE ☐ YELP ☐ EMAIL
☐ Walk In ☐ Other Patient ..Name:_____

Race: ☐ Asian ☐ Black / African-American ☐ Hispanic/Latino ☐ White ☐ Hawaiian ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other

Emergency Contact:_____ **Phone:**_____

Primary Care Doctor:_____**Ph:**_____

VISION Insurance (vsp, eyemed, superior, etc.)

Vision Insurance:_____☐**SAME AS ABOVE** ☐ Relationship to Patient _____

Subscriber Name:_____ **SS #**_____**DOB**_____
Last First

MEDICAL Insurance (Aetna, cigna, UHC, BCBS,etc.)

Medical Insurance:_____ ☐ **Subscriber Info SAME AS ABOVE**

Subscriber Name:_____ **SS #**_____ **DOB**_____
Last First

ID #_____**Group #**_____ _____**Relationship to Patient**_____

ASSIGNMENT, CONSENT AND RELEASE

I have reviewed "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that as part of treatment, payment, or healthcare operations, it may be necessary to disclosure health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

Optomap Retinal Imaging - Our office strives to provide a comprehensive evaluation of your eyes. Examination of the inside tissue of the eye called the retina is very critical. On an annual basis, an Optomap Screening of your Retina will be performed. We now offer this at no additional cost to you as part of our mission to provide a comprehensive eye health examination!

_____ _____ _____
Signature of patient, parent, guardian Please print name Date