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 POSTCARD EMAIL Social Media
Walk In Other Patient ..Name:_________________________

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

Emergency Contact:______________________________ **Phone:**_______________________

Primary Care Doctor:_________________________________**Ph:**__________________________

PRIMARY Member Information

MEMBER Name:____________________________________ **SS #**__________________________**DOB**_______________
Last First

Member's City:________________ **State:**________ **Zip Code:**_________ **Relationship to Patient**________________

Vision insurance AND Medical Insurance

<u>VISON (vsp, eyemed, superior vision, davis, spectera, etc)</u>

Vision Insurance Name:_______________________________ **ID:**___________________________________

<u>MEDICAL (bcbs, cigna, uhc, etc)</u>

Medical Insurance Name:____________________________ **ID:**_________________________**Group :**_____________

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.

<u>Optomap Retinal Imaging -</u> 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