Welcome To Our Office

Thank you for choosing our office for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

Patient Information (Please Print):

Name _____ **Birthdate** ___/___/_____ **S. S. Number** ___-__-_____
First MI Last

Address _____ **City** _____ **State** ___ **ZIP** _____

Email Address _____

How did you hear about our office? _____

I prefer to be contacted at the following phone number(s):

Cell _____ **Home** _____ **Other** _____

Emergency Contact Information:

Emergency Contact Name _____ **Phone Number** _____

Insurance Information:

Name of Insured _____ **Relationship to Patient** _____

Birthdate of Insured ___/___/_____ **S. S. Number of Insured** _____-___-_____

Name of Employer _____

❒ **I, the undersigned, assign directly to Kemperas Eyecare all vision benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance, and payment is expected at time services are rendered, unless other arrangements have been made. I hereby authorize Kemperas Eyecare to release all information necessary to secure payment of benefits.**

❒ **I acknowledge that I read and received a copy of Tom Kemperas, O.D., Notice of Privacy Practices.**

Signature _____ **Date** ___/___/_____