

Patient Account # _____

**Indiana University
School of Optometry**

Today's Date _____

Patient InformationTitle _____ Gender M F Patient Name _____
Last First MiddlePatient Address _____
Street City State Zip

Patient Home Phone _____ Patient Work Phone _____

Patient Cell Phone _____ Patient e-mail _____

Patient Date of Birth _____ Student ID # (if applies) _____

Employer _____

Person Responsible for Payment **and/or** **Permanent Address** Name _____
Last First MiddleAddress _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____

Insurance Information**Patients must present insurance card prior to exam.**

Type of Insurance _____ Relationship to Subscriber _____

Subscriber's Name _____ DOB _____ Ins ID # _____

Please answer the following questions:**May we bill to your bursar account?** Yes No Yes No

I authorize IU School of Optometry Faculty or Investigators to publish any photographs or pertinent information concerning any care as may be needed for professional medical journals, books, or seminars in the interest of medical education, knowledge, and research. I understand that I will not be mentioned by name nor will I be identifiable from my photographs.

Yes No

If I qualify for an upcoming research investigation, please inform me so that I may consider participating.

Yes No

I authorize Indiana University School of Optometry (IUSO), its agents, and employees, and their agents and employees (collectively referred to as "Healthcare Providers") to furnish optometric care and services, including but not limited to, diagnostic tests, examinations, and other medical and/or surgical procedures, which is deemed necessary in the course of my care. I understand that IUSO is an educational institution and I agree that student interns (in training to be Optometry Doctors and Optical Technicians) may assist in providing my care and that my optometry records may be used for the purposes of research, education and patient care.

In compliance with CLAS Standards we are required to ask the following questions:

What is your preferred language of communication? _____

What is your ethnic origin and or racial group? _____

Privacy Practices**I give my permission to the School of Optometry to release information about my medical and/or financial to the following person(s) or optometry practice(s) listed here.**

Name _____ Phone _____

Name _____ Phone _____

My signature below confirms that I have received the "Notices of Privacy Practices" and its explanation of how the School of Optometry will use my personal health information in relation to treatment, payment and healthcare operations, as well as my rights regarding the management of this information.

Patient or Guardian Signature: _____