

**Indianapolis Eye Care Center**  
Indiana University School Of Optometry

Acct/File# \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
(Last, First, Middle)

Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse: \_\_\_\_\_

Parent/Guardian (if patient is a minor): \_\_\_\_\_

Person responsible for payment if different than above: \_\_\_\_\_

Circle one: Medicare Hoosier Healthwise BC/BS VSP Spectera IU Health IU Bursar Voc Rehab DAV HIP  
GFC MPLAN METLIFE First Steps Lions Club West Ctrl Joint Self Other

Member Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Please answer the following questions:

YES /  NO I authorize the Indiana University 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 Indianapolis Eye Care Center to file for my insurance benefits.

Patient Signature: \_\_\_\_\_