

Patient Account # _____

**Indiana University
School of Optometry**

Please review all information below, filling out all requested information

Patient Information

Gender _____ Title _____ Patient Date of Birth ____/____/____

Patient Name

Last First Middle

Patient Address

Street City State Zip

Patient Home Phone _____ Patient Work Phone _____ ext. _____

Patient Cell Phone _____ Last 4 Digits of SSN

Primary Care Provider: _____ PCP Phone: _____ PCP Fax: _____

Email _____ Employer _____

What is your preferred **language** of communication? _____

Patient Communications: How do you prefer to receive appointment reminders?

Email ☐ Text ☐ Phone ☐

Do you want to participate in the patient portal? Yes ☐ No ☐

Race: American Indian or Alaska Native ☐ Asian ☐ White ☐
Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐
Ethnicity (check one): Not Hispanic or Latino ☐
Hispanic or Latino ☐

Person Responsible for Payment ☐ and/or **Permanent Address** ☐

Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____

Insurance Information

Patients must provide insurance card prior to exam.

Type of Insurance _____ Relationship to Subscriber _____

Subscriber's Name _____ DOB _____ Ins ID # _____

If you are an Indiana University student may we bill your bursar account? Yes ☐ No ☐

Individuals Involved in Care

IUSO may speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services. (If they are an EMERGENCY CONTACT, please check the EC box.)

Name _____ Phone _____ ☐ EC

Name _____ Phone _____ ☐ EC

Notice of Privacy Practices: I acknowledge, by my signature below that I have been given the opportunity to review the Notice of Privacy Practices for IUSO and I understand that I may request a copy of this notice should I so choose.

Financial Agreement: I have read and understand the IUSO Financial Agreement and agree to comply with these terms. I understand my insurance company may make payment directly to IUSO and its clinics for services and/or materials rendered. I understand IUSO may release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorization to Treat: I authorize 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.

Patient or Guardian Signature: _____ **Date:** _____