INDIANA UNIVERSITY SCHOOL OF OPTOMETRY
PATIENT INFORMATION FORM

First name		Last name				Middle initial	
Nickname		Gender		Title		Last 4 of SSN	
Date of Birth		Preferred Language					
Address		City		State		Zip	
Home Phone			Work Phone				
Cell Phone			Email				
Employer							
Primary Care Provider		Phone		Fax			

Race/Ethnicity—please mark up to two choices for race and one choice for ethnicity									
Race	☐	White	☐	Asian	☐	Black or African American	☐	American Indian or Alaska Native	
	☐	Native Hawaiian or Other Pacific Islander							
Ethnicity	☐	Not Hispanic or Latino			☐	Hispanic or Latino			

Insurance information (patients must provide insurance card prior to exam)				
	Subscriber Name	Relationship to subscriber	Subscriber DOB	Insurance ID#
Vision Carrier				
Medical Carrier				

Responsible Party Billing Information					
☐ Check this box if your billing information is the same as the above					
Name					
Street					
City		State		Zip	
Home Phone		Work Phone			
Cell Phone		Email			

Individuals with whom we may share medical information (spouse, children, parents, caregivers, etc.) Please mark the EC box if they are an emergency contact.				EC ☐
Name		Phone		
Name		Phone		
Name		Phone		

If you are an Indiana University student may we bill your bursar account?	☐	Yes	☐	No
Do you wish to participate in the patient portal?	☐	Yes	☐	No

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 "health-care 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 _____