PATIENT INFORMATION FORM

Indiana University School of Optometry

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							
Cellphone		Email							
Employer									
Primary Care Provider		Phone		Fax					
Preferred Local Pharmacy									
Preferred Mail Order Pharmacy									

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			
Cellphone		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 "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 during 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** _____