RESPONSIBLE PARTY INFORMATION (This is **not** insurance information)
If the patient is a minor, the parent the minor lives with is the responsible party.

First and Last Name: ______________________________

Social Security Number: ____________ Birth Date: ________ Home/Cell Phone: ____________

Street Address: ______________ City: ____________ State: ________ Zip Code: ____________

Employer: ______________________________ Work Phone: ____________

SPOUSE INFORMATION OR OTHER PARENT
First and Last Name: ______________________ Home/Cell Phone: ____________

Employer: ______________________________ Work Phone: ____________

INSURANCE INFORMATION
Do you have Vision Insurance?: Yes ☐ No ☐ Name of the Insurance Company: ____________

Member ID: ____________ Policy Holder's Social Security Number: ____________

Policy Holder's Name: ______________________ Policy Holder's DOB: ____________

Patient's relationship to the Insured (Self, Spouse, Child, Dependant, Other): ____________

Do you have Medical Insurance?: Yes ☐ No ☐ Name of the Insurance Company: ____________

Member ID: ____________ Policy Holder's Social Security Number: ____________

Policy Holder's Name: ______________________ Policy Holder's DOB: ____________

Patient's relationship to the Insured (Self, Spouse, Child, Dependant, Other): ____________

Has any member of your family been treated at our office before?: Yes ☐ No ☐

If yes, please list the patient's name: ______________________________

How did you hear about us?: ______________________________

Acknowledgement of Receipt of Privacy Notice
I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand I have the right to restrict disclosure of specific information in my records, if I request such restrictions in writing. I also understand that my request may be denied if the information is required for Health Care Operations.

By signing below, I am acknowledging the Privacy Practice Notice and authorizing Nanston Vision to release medical records at my request, including but not limited to patient prescriptions, medical information and history, and diagnosis for the patient listed to any physician providing medical care to the patient listed for the purpose of medical care unless indicated otherwise.

Please note: Payments are due when services are rendered unless prior arrangements have been made. Although you are responsible for the entire bill when services are rendered, as a courtesy to you, if applicable, it is our policy to bill your insurance carrier for payment partially or in full. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you.

Signed: ______________________________ Date: ____________