PRECISION EYECARE

Patient Information

Name_____Date_____
Age_____Birth Date_____M/F____ Social Security #_____
Race: American Indian____Asian____Black/AA_____Hispanic____Pacific Islander____White_____
Mailing Address_____
City_____State____Zip_____ Email address_____
Phone (home/cell)_____(work)_____
Emergency Contact_____Emergency Phone_____Relationship_____

Change of Address_____

How did you first hear about our practice?

___Friend ___Family member ___Google
___Facebook ___Insurance Plan ___Another Doctor ____Passing By ___Other

Whom may we thank for telling you about our practice?_____

Acknowledgement of Notice of Privacy Practices

I have read or had explained to me prior to any services offered, Precision Eyecare's Notice of Privacy Practice and agree to continue my care with Precision Eyecare under said terms. I am signing it voluntarily.

Signature of patient or guardian_____Date_____

Insurance Information and Signature

Provider: Eric Porisch, O.D. 605 Saint Joseph Street Rapid City, SD 57701

We are happy to utilize your medical and/or vision benefits. If you are not eligible for these benefits, or are eligible for less than full coverage, your signature below indicates that you agree to be financially responsible for any balance that is not paid by your plan.

I authorize payment of medical benefits to myself or the named provider for professional services rendered. I authorize the release of any medical or other information necessary to process this claim.

Signature of patient or guardian_____Date_____

Insurance Subscriber's Name_____Male/Female_____
Subscriber's Date of Birth_____Social Security #_____
Address if different than patient_____
Insurance Co._____Group #_____ID#_____
Relationship to patient: ___self ___spouse ___parent/guardian

Exam fees are payable to Precision Eyecare upon completion of eye exam.

****Please turn over and complete back page****