Doctors of Optometry

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doctorscentarandimler.com
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PATIENT INFORMATION

Please print this form, sign & date it and bring it with you to your first appointment. Thank you.

Welcome to Drs. Centar and Imler. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. _____
First Name MI Last Name Preferred Name

_____ ❑ Male ❑ Female
Street Address City State Zip

__/__/__ __/__/__
Social Security Number Date of Birth Home Phone Work Phone

Email Address Person Responsible for Account Emergency Contact Emergency Phone

VISION INSURANCE INFORMATION

MEDICAL INSURANCE INFORMATION

Vision Insurance Company Name *Medical Insurance Company*

PRIMARY CARE PHYSICIAN

Primary Care Physician And Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

Height ____ *ft* ____ *in* ____ *cm/m* *ft in* ◉ *cm* ○ *m* ○ *Weight* ____ *lbs* ◉ *kg* ○

RACE

❑ *American Indian of Alaskan Native*
❑ *Asian*
❑ *Black or African American*
❑ *Native Hawaiian or Other Pacific Islander*
❑ *Other Race*
❑ *White*
❑ *Native American*
❑ *Caucasian*
❑ *Refuse to Specify*
❑ *Not Disclosed*

Ethnicity ❍ *Hispanic or Latino* ❍ *Not Hispanic or Latino* ❍ *Unknown*

Other Race

Preferred Language ❍ *English* ❍ *Spanish* ❍ *French* ❍ *Italian* ❍ *Russian* ❍ *Portuguese*

How were you referred to our office?

❑ *Phone Book* ❑ *School* ❑ *Advertisement* ❑ *Patient (Please Name)*_____

❑ *Insurance Listing* ❑ *Drive By* ❑ *Other* *Doctor (Please Name)*_____

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient . The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Drs.Centar and Imler. I understand that charges will be billed to my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Notice of HIPPA Privacy Policy: I acknowledge I have read and/or received Drs. Imler & Centar O.D.'s Notice of Privacy Practices.

_____
Patient Signature *Date*