Dr. Kelly Campbell
Residency Trained Optometrist

Dr. William Stuever
Optometrist

Patient Legal Name:____**Sex**: **M** **F**

Date of Birth:______/______/______ **Marital Status**: **S** **M** **D** **W**

SSN:___________________________________**Name of Spouse/Parent**:_____________________________

Address:______________________________**City**:_____________________**State**:_______**Zip**:_________

Preferred Phone:______________________**Home/Cell/Work** **Additional Phone:**_______________

Email:____**Preferred Communication Method**: ☐ Phone ☐ Text ☐ Email

Insurance Information: (please provide cards)

Primary Insurance:____

Name of Insured:____**Insured's DOB:**_____/______/______

Secondary Insurance:____

Name of Insured:____**Insured's DOB:**_____/______/______

Race: American Indian or Alaskan Asian or Pacific Islander Black White Hispanic Other

Preferred Language: English Spanish

How did you hear of Family Vision Care? Newspaper/Yellow Pages/Insurance Co./Facebook/Website
Referring Doctor/Friend that we can thank:____

All patients **MUST** sign the following statements or Family Vision Care of Ponca City will not be able to provide care.

I fully agree and understand that payment is ***due at time of service***. I fully agree that I am responsible for all services and co-payments not covered by my insurance company (should that apply). ***Financial arrangements, if needed, should be made prior to treatment***. **I hereby authorize release of information for insurance claim purposes.**

I authorize Family Vision Care of Ponca City or their representatives, including collection agencies, to contact me via cell phone, email, or wireless device (including use of automated dialing equipment) regarding my account should it become delinquent. I understand that I may withdraw my consent to call my cellular phone at any time by submitting my request in writing to Family Vison Care of Ponca City or its agents.

Patient/Guarantor:____**Date:** _______/______/______

By signing this, I am acknowledging that I have been provided a copy of Family Vision Care of Ponca City's Notice of Privacy Practices, as required by ***HIPPA***.

Patient/Guarantor:____**Date:** _______/______/______