

Patient Information

Welcome to Shinmori Optometry. The security and privacy of your personal data is one of our primary concerns and we have taken every precaution to protect it. Thank you for your trust and we appreciate the confidence you placed in us!

Mr. Mrs. Ms. Dr. Today's Date _____
Name (first / initial / last) _____
Address _____ Home Phone _____
City/State/Zip _____ Work Phone _____
Date of Birth _____ Cell/Other Phone _____
Email _____

Name of individual responsible for account _____
Relationship to the patient Self Spouse Father Mother Other
Address (if different from above) _____
Email (if different from above) _____ Phone _____

Insurance Information

Employed: Full-Time Part-Time Not working Retired
Student: Full-Time Part-Time Marital Status: Married Other
Occupation: _____

VISION Insurance

Vision Insurance Company _____
Name of Primary Subscriber _____
Subscriber birthdate _____ Subscriber's Social Security # _____

Secondary Vision Insurance (if applicable)

Vision Insurance Company _____
Name of Primary Subscriber _____
Subscriber birthdate _____ Subscriber's Social Security # _____

MEDICAL Insurance PPO HMO Medicare Other

Please bring your medical card so we may make a copy to include in your records.

Medical Health Insurance Company _____
Name of Primary Subscriber _____
Subscriber birthdate _____
Insurance ID / Policy # _____

Secondary Medical Insurance (if applicable)

Medical Health Insurance Company _____
Name of Primary Subscriber _____
Subscriber birthdate _____
Insurance ID / Policy # _____

I authorize Shinmori Optometry to bill my vision and/or medical insurance for services rendered and request that all payments be made directly to the vision care provider. As your optometric care provider, our relationship is with you, our patient, and not with your insurance company. I understand that I am responsible for any insurance co-payments and unpaid portions the insurance denies or does not cover. We kindly request that professional services be paid for at the time rendered. When vision insurance is not involved, a deposit of at least half the cost of materials must be made on the date ordered. The balance is to be paid at dispensing.

Signature _____ Date _____
Relationship to patient (if patient is a minor or patient is unable to sign): _____