

Welcome to Dr. Funnell Optometry!

Today's Date: _____

SECTION 1: PATIENT INFORMATION

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ Gender Female Male

Home Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Alternate# _____

Email Address _____

Please do not send me periodic emails with special information or offers. Your email is never sold or used for other purposes.

Race

Caucasian/White African American Asian American Indian Hispanic/Latino Pacific Islander Other Decline to Answer

Ethnicity

Hispanic Non-Hispanic

Preferred language if not English

SECTION 2: RESPONSIBLE PARTY/PARENT/GUARANTOR *for patients less than 18 years old*

Relationship to Patient

Self (*skip this section*) Spouse Parent Other _____

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ Gender Female Male

Home Address _____ City _____ State _____ Zip _____

Same as Patient's

I authorize the Dr. Funnell to treat/care for this child .
This consent is given pursuant to the provisions of section 25.8 of the Civil Code of California.

Signature _____ Date _____

SECTION 3: EMERGENCY CONTACT INFORMATION

Last _____ First _____ Relationship to Patient _____

Preferred Phone _____ Home Work Cell _____

SECTION 4: PRIVACY RIGHTS ACKNOWLEDGEMENT

I have read the Dr. Funnell Privacy Notice and understand my rights contained therein. By way of my signature, I acknowledge that the Dr. Funnell Optometry has provided me with a policy regarding the use and disclosure of my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice. A copy shall be as valid as the original.

Signature _____ Date _____

SECTION 5: INSURED INFORMATION

Relationship to Patient

Self (*skip this section*) Spouse Parent Other _____

Last _____ First _____ Middle Initial _____ Title _____

Last four digits of SSN# _____ Date of Birth _____ Gender Female Male _____

SECTION 6: VISION INSURANCE INFORMATION (*VSP, Eyemed, MES*)

Present your insurance card(s) to the receptionist.

Name of Insurance _____

Name of Insurance _____

Member ID# _____

Member ID# _____

SECTION 7: MEDICAL INSURANCE INFORMATION (*Anthem Blue Cross, Blue Shield, Medicare, Medi-Cal, and supplemental*)

We do not accept HMO's. Present your insurance card(s) to the receptionist.

Name of Insurance _____

Name of Insurance _____

Member ID# _____

Member ID# _____

If the patient is covered by more than one plan, please use the below boxes to list plan(s) type.

Name of Insurance _____

Name of Insurance _____

Member ID# _____

Member ID# _____

SECTION 8: HOW DID YOU HEAR ABOUT US?

How did you hear about us? *Please check all that apply.*

Referred by doctor

Social Media Ad: Facebook

Recommended by friend or family

Social Media Ad: Instagram

Online Search

Other _____

Online Ad