Dr. Joseph Vincent
Dr. Justine Redlin

NP Intake 1

TREASURE STATE
EYE CARE

Patient's Name _____
First **Middle** **Last**

Age _____ Sex _____ Date of Birth _____/_____/_____ Patient's SSN # _____-____-_____

Mailing Address _____ City _____ State _____Zip Code_____

Primary Phone (____)_____

Occupation/Employer _____ Work Phone Number (____)_____

Marital Status (circle one) Single Married Separated Divorced Widowed

Primary Vision Insurance _____ Secondary Carrier _____
Responsible Party _____ DOB ____/____/_____ SSN# _____-____-_____

Primary Medical Insurance _____ Secondary Carrier _____
Responsible Party _____ DOB ___/____/_____ SSN# _____-____-_____

Treasure State Eye Care offers the ability to conveniently send appointment reminders, notify you when glasses and contact lens orders are ready to be picked up, and allow you the ability to communicate efficiently with our office via text messages and e-mail. Your information will only be used by this office for official business and will not be sold to marketers. This feature can be opted-out of at any time.
Cell Phone (____)_____ E-Mail_____

Do you have any member of your immediate family who, or has been, at patient of Treasure State Eye Care? If yes, please list them here: _____

How did you hear about Treasure State Eye Care? (please circle one): Family/ Friend _____

Yellow Pages Newspaper Sign Internet Facebook Instagram

Most insurance companies pay only a portion of your total charges. If you have questions on coverage, please contact your insurance company's representative. We can not guarantee the accuracy of benefit information given to us by the insurance company. Please understand that the financial responsibility of your account is yours, not your insurance company's. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits to the practitioner or supplier of services rendered or myself if the provider does not accept assignment. I understand that I am responsible for any balance that my insurance does not pay.
Signed: _____ Parent/Guardian: _____ Date: _____

Acknowledgment of Receipt of Privacy Practices
I Acknowledge that I received a copy of Treasure State Eye Care's "Notice of Privacy Practices.

Full Name (printed):_____ Signed _____ Date:_____