



PATIENT INFORMATION								
Please check the following information for accuracy. Make any necessary corrections and fill in any missing information. Sign and date the bottom of this form. Thank you for your cooperation and keeping your information up to date so that we may serve you better!								
ACCOUNT #:								
LAST NAME:								
FIRST NAME:					MIDDLE INITIAL:			
ADDRESS:								
CITY:				STATE:			ZIP CODE:	
DOB:			SOCIAL SECURITY #			GENDER:	M F	
HOME PHONE #:				CELL PHONE #:				
MARITAL STATUS:	SINGLE MARRIED DIVORICED SEPARATED WIDOWED OTHER							
EMPLOYER:								
OCCUPATION:				WORK PHONE #:				
SCHOOL:					GRADE:			
EMAIL ADDRESS:								
EMERGENCY CONTACT INFORMATION								
NAME:								
PHONE #:								
RELATIONSHIP:								
GUARANTOR INFORMATION								
<small>(FOR DEPENDENTS UNDER AGE 18)</small>								
NAME:								
ADDRESS:								
CITY:								
STATE:				ZIP CODE:				
PHONE #:				RELATIONSHIP:				
PRIVACY PRACTICES ACKNOWLEDGEMENT AND INSURANCE PAYMENT AUTHORIZATION								
I acknowledge that I have received a copy of the Notice of Privacy Policy of Optometric Associates of Warren County, P.C. to review. I authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry for goods or services rendered. I permit a copy of this authorization to be used in place of the original signature and authorize release of medical information necessary to pay the claim. I understand that I may have co-payments, deductibles, and overage costs and that I am responsible for all fees incurred, and that payment is expected at the time of service or at the time I receive materials ordered.								
X _____							DATE: _____	

Indianola
225 W. Ashland Ave
Indianola, IA 50125
515-961-5305

Carlisle
55 School Street
Carlisle, IA 50047
515-989-0889

Norwalk
1228 Sunset Drive
Norwalk, IA 50221
515-981-0224