Welcome to our office! We appreciate your trust in our care.

Dr. Denise Hanson, Dr. Tara Kempfer, Dr. Randy Kempfer, Dr. David Hilber and the entire staff are dedicated to making your visit comfortable and informative. Please let us know if there is anything we can do to assist you with your vision care. As a courtesy we will be happy to submit any applicable services to your insurance plan.

All information is strictly confidential.

General Patient Information

Last name ______________________ First name ______________________ MI _____

Nickname ______________ Birthdate _____/_____/______ Gender: ________ Spouse ______________

If ***18 or under***, Parents/Guardians: ______________ / ______________ I live with: ____________

Street ____ Apt/Unit #______________

City ______________________ State: ______________ Zip ______________

Home phone ______________ Work phone ______________ Cell phone ______________

Email address:____

Occupation / Grade ______________________Employer / School______________________

Were you referred to our office? Y N If yes, by whom? ______________________________

Authorizations & Releases

☐ **I authorize InVision Eye Care to release any information, including my diagnoses and examination records and/or my dependent during the time period of such care as required by my insurance companies or other third party payer. I further authorize and request my insurance company or payer to pay any benefits directly to InVision Eye Care.**

☐ **I agree to be responsible for any portion of the bill not covered by my insurance companies or third party payer.**

☐ **I authorize InVision to release my examination records to any specialist should I be referred for further care.**

☐ **I acknowledge that I received or was offered a copy of InVision Eye Care's Notice of Privacy Practices.**

☐ **I authorize the release of my health/appointment information to the following individuals:**

____

Please list - spouse, significant others, family members, step parents -if under 18 – Void after 10 years

☐ ***Would you like InVision's patient communication system to send you texts and/or emails to remind you about upcoming appointments, notify you of special events?***
Please circle yes or no - Texts: YES / NO Emails: YES / NO
I agree to allow InVision's patient communication system access to this information for this purpose.

______________________________ ______________________________ ______/______/______
Print Patient Name **Authorized Signature** **date**