Welcome to Our Office

Dr. Barry Huse and Associates

Patient Name: ____ SSN:______________
(last, first, middle)

Birth Date: _________ Gender Assigned at Birth: Male / Female Preferred Pronouns: ________

Address: ______________________________ City:____________ State: ______ Zip _______

Home Phone: _______________ Cell Phone: _______________ Text Ok?: Yes / No

Email: _____________________________________ Preferred Method of Contact: _________

Emergency Contact Name, Number and Relationship: _________________________________

Primary Care Physician Name and Office Location: __________________________________

Vision Insurance Information

Name of Insured Person: __________________________ Relationship to Patient: __________

Birth Date: ___________ SSN: __________________ Insurance Company: _______________

Policy Number: __________________________ Group Number: _______________________

Primary Medical Insurance

Name of Insured Person: __________________________ Relationship to Patient: __________

Birth Date: ___________ SSN: __________________ Insurance Company: _______________

Policy Number: __________________________ Group Number: _______________________

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges and authorize my insurance benefits to be paid directly to the provider of service. I am financially responsible for all non covered services and payment is due at the time services are rendered.

Signature: ____ Date: ___________