# Welcome to Staarmann Family Vision Center

*Professional Eyecare with a Personal Touch*

First Name: M: Last Name: I prefer to be called:

Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Date of Birth: Gender: M F SS#: Email:

Marital Status: ☐ Single ☐ Married ☐ Other Ethnicity (optional): Race (optional):

Preferred Language: Employer/School: Occupation/Grade:

Hobbies:

Communication Preference: (email phone text postal)

Whom may we thank for referring you to our office?

Emergency Contact: Relationship: Phone:

Primary Physician: Last medical exam: Last eye exam: Where:

**INSURANCE INFORMATION**

Vision Insurance: ID #:

Medical Insurance: ID #:

Subscriber Name: Relationship to Patient: Date of Birth:

**FINANCIAL RESPONSIBILITY & INSURANCE AUTHORIZATION**

Staarmann Family Vision Center will file insurance claims for all insurance companies with whom we have an active contract with. If we are an out-of-network provider for your insurance plan, we will provide you will all necessary paperwork so that you may submit to your insurance carrier for reimbursement. It is your responsibility to know your insurance company's coverage and limitations. You will be responsible for any portion of fees not covered or not paid by your insurance company.

**AUTHORIZATION: I authorize Staarmann Family Vision Center to release any necessary information required for insurance processing. I agree to pay in full at the time of service all copays, deductibles, co-insurances and not covered items as determined by my insurance company.**

Patient (legal guardian if under 18):_____ Date: _____

**PRIVACY POLICY ACKNOWLEDGEMENT**

**I acknowledge that I have been offered a copy of the "Notice of Privacy Practices" from Staarmann Family Vision Center.**

Patient (legal guardian if under 18):_____ Date: _____