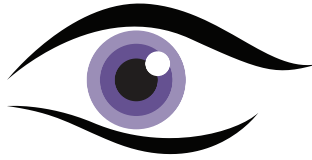

RANCHO SANTA FE
OPTOMETRY

Dr. Elizabeth Christensen, OD., F.C.O.V.D.
Diplomate, A.B.O.

NEW PATIENT INFORMATION - ADULT

Last Name ____________________ First Name ____________________

Nickname ____________________ Title ____________________

Mailing Address ____

Street Address (if different) ____

City ____________________ State __________ Zip __________

Daytime Phone ____________________ Cell Phone ____________________

Email Address ____

Date of Birth ____________________ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number ____

Employer ____________________ Occupation ____________________

How were you referred to our office? Family Friend Online Search

Referred Name *(so we can thank them)* ____

Meaningful Use *is using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities, engage patients and family, improve care coordination, and public health and to maintain privacy and security of patient health information. Please fill out the following information, So we are in compliance with these standards:*

Preferred Language ☐ English ☐ Other ____________________

Race ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic
☐ Pacific Islander ☐ Caucasian ☐ Declined to Specify

Ethnicity ☐ Hispanic/Latino ☐ Pacific Islander ☐ Not Hispanic/Latino

Communication Preference ☐ Email ☐ Postal ☐ Telephone ☐ Text

Primary Care Physician (PCP) ______________________________

Would you like a report of your exam sent to your PCP? ☐ YES ☐ NO

Please be prepared to share your health and eye history with Dr. Christensen. Bring all current glasses, contacts and a list of your current medications.

VISION INSURANCE

☐ *Patient has no vision insurance*

Insurance Name ______________________________

Policy Group No. ______________ ID No. ______________

Insured Party Full Name ______________________________

Date of Birth ______________ Last 4 SSN#: ______________

Relationship to Insured ______________________________

HEALTH INSURANCE

Insurance Name ______________________________

Policy Group No. ______________ ID No. ______________

Insured Party Full Name ______________________________

Date of Birth ______________ Last 4 SSN#: ______________

Relationship to Insured ______________________________

CONSENT FOR TREATMENT, TO RELEASE INFORMATION & PAYMENT AGREEMENT
I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at the offices of Elizabeth Christensen, O.D. I have received a copy of the privacy statement of Elizabeth Christensen, O.D.

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

Signature of Responsible Party ______________________________ Date ______________

PHONE | 858.756.3210 FAX | 858.756.3910 EMAIL | INFO@RSFOPTOMETRY.COM

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Fellow: College of Optometrists in Vision Development