Dale N. Holdren, MD
K. Scott Sorensen, MD
John V. Hardaway, MD

Jason G. Gagnon, OD
Debra M. Sorensen, OD

Kitsap Eye PHYSICIANS

PATIENT/MINOR INFORMATION

Last Name: _____ First Name: _____ MI: ___

DOB: _____ ☐ Male ☐ Female Primary Phone #: _____ □Home □Mobile

Do you prefer appointment Reminders: □ Call □ Text □ Email

Mailing Address: _____
Street/PO Box # City State Zip Code

Physical Address: _____
Street/PO Box # City State Zip Code

Parent/Guardian: _____ Phone: _____

In case of EMERGENCY contact:

Name: _____ Phone: _____

ADDITIONAL PATIENT INFORMATION

Race / Ethnicity- Please mark all that apply:

American Indian / Alaskan Native
Native Hawaiian / Pacific Islander
Other: _____
African American
Hispanic / Latino
Declines
Caucasian
Asian

Primary Language: English Spanish Other: _____ **Gender Identity**: _____ (optional)

KITSAP EYE PHYSICIANS
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you, and under federal law, your patient health information is protected and confidential. Our notice of privacy practices is available at your request. In addition to allowable disclosures in the notice of Privacy Practices, I hereby authorize disclosure of my protected healthcare information to the person(s) indicated below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ I do not wish to have Kitsap Eye Physicians leave me messages containing protected healthcare information.

I acknowledge the information is accurate and I have been informed that a copy of the Notice of Privacy Practices is available to me.

Patient / Guardian Signature: _____ **Date**: _____

Please read and sign the other side

PARENT/GUARANTOR INFORMATION

Last Name: _____ First Name: _____ MI ___

DOB: _____ SSN: _____

Address: _____
Street/PO Box # City State Zip Code

Phone: _____ Insurance Name: _____

Employer: _____ Work Phone: _____

RELEASE OF INFORMATION / FINANCIAL DISCLOSURE

I give permission to Kitsap Eye Physicians to bill my insurance company whether the benefits are to come to me or to Kitsap Eye Physicians. It is my understanding that I am eligible for routine vision and medical benefits through my insurance. However, in the event that my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary", I agree to pay in full for all such charges. I fully understand that it is my responsibility to advise Kitsap Eye Physicians if my insurance requires pre-admission review, pre-admission authorization, or a second opinion, or if it contains any special provisions (to include exclusionary rider) which must be satisfied before payment by the insurance company can be made. If I fail to advise Kitsap Eye Physicians of such policy requirements and to comply in good faith, I agree to pay in full for all such charges.

If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Doctor. (Co-pays will be made at time of service.) I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplies by my Primary Care Doctor.

The signature below authorizes direct assignment of benefits to Kitsap Eye Physicians.

Patient Name: _____
Please Print

Patient / Guardian Signature: _____ **Date**: _____