

K. Scott Sorensen, MD  
John V. Hardaway, MD



Jason G. Gagnon, OD  
Debra M. Sorensen, OD  
Joy C. Schnoebelen, OD

**PATIENT INFORMATION**

FULL LEGAL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

MALE  FEMALE  NON-BINARY SSN #: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
Street/PO Box City State Zip Code

PHYSICAL ADDRESS: \_\_\_\_\_  
Street/PO Box City State Zip Code

PRIMARY PHONE #: \_\_\_\_\_ Mobile / Home ALTERNATE PHONE #: \_\_\_\_\_

EMAIL: \_\_\_\_\_

HOW WOULD YOU PREFER YOUR APPOINTMENT REMINDERS: :  CALL  TEXT  EMAIL

EMPLOYER: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ CLINIC/LOCATION: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_

**ADDITIONAL PATIENT INFORMATION**

RACE / ETHNICITY – PLEASE CHECK ALL THAT APPLY:  AMERICAN INDIAN/ALASKA NATIVE  AFRICAN AMERICAN  
 ASIAN  CAUCASIAN  HISPANIC/LATINO  NATIVE HAWAIIAN/PACIFIC ISLANDER  
 OTHER: \_\_\_\_\_  DECLINES

PRIMARY LANGUAGE:  ENGLISH  SPANISH  OTHER: \_\_\_\_\_

**RELEASE OF INFORMATION / FINANCIAL DISCLOSURE**

I give permission to Kitsap Eye Physicians to bill my insurance company whether the benefits 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, 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/or 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 supplied by my Primary Care Doctor.

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

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### 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 the allowable disclosure in the notice of Privacy Practices, I hereby authorize disclosure of my protected healthcare information to the person(s) indicated below:

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

### EMERGENCY CONTACT(S):

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship

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

Patient Name: \_\_\_\_\_  
Please Print Name

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_