

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



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

PATIENT/MINOR INFORMATION

FULL LEGAL NAME: _____ DOB: _____

MALE FEMALE NON-BINARY

MAILING ADDRESS: _____
Street/PO Box City State Zip Code

PHYSICAL ADDRESS: _____
Street/PO Box City State Zip Code

PARENT/GUARDIAN: _____ 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: _____

PARENT/GUARANTOR INFORMATION

FULL LEGAL NAME: _____ DOB: _____

SSN #: _____

PHONE#: _____

MAILING ADDRESS: _____
Street/PO Box City State Zip Code

EMPLOYER: _____ WORK PHONE #: _____

INSURANCE NAME: _____

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PATIENT FULL LEGAL NAME: _____ DOB: _____

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 Name: _____

Parent/Guardian Signature: _____ Date: _____

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

EMERGENCY CONTACT(S):

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

Parent/Guardian Signature: _____ Date: _____