Lohmueller & Associates, O.D.

1049 State Road 229
Batesville, IN 47006

Date: ________________ Daytime/Home Phone: (_____)________________

Patient:______________________________ Cell Phone: (_____)____________________

OK to receive Text Messages: YES or NO

Street Address: ____________________________________

City:____________________________________ State:______________ Zip:________________

Sex: __M__ _F____ Date of Birth:________________ Social Security #__________________________

Single	Married	Widowed	Divorced	Separated

Patient Employed by:________________________________

____

Occupation: ___________________________________

Primary Insured Name:______________________________ Date of Birth: ________/________/________

____ Social Security #: ______________________

Insured's Work:___________________________________ Phone: (________) ______________________

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Occupation: ___________________________________

In case of emergency, notify: __________________________ Phone: (________)______________________

Preferred Language:

English	Spanish	French	Japanese

Communication Preference:

Email	Telephone	Postal

Email Address: ____

Preferred Pharmacy ____

Permission to access prescription information or history __Y____N____

I agree to be fully responsible for total payment of services performed including any amounts not covered by health insurance, vision insurance or prepayment programs I may have. The policy in our office is that the parent who requests treatment for a minor child is responsible for all fees for services rendered. (If insured). I authorize the release of information requested by my insurance company for the purpose of payment of insurance benefits. I authorize payment directly to Carol A Lohmueller, O.D. LLC. A copy of this authorization shall be valid as the original.

Patient (print name) ______________________________________

Patient (signature) ______________________________________ Date: ____________________

You must be 18 or older to sign. If under the age of 17 legal guardian or parent must sign.