Custom Eyes / Michael K. Estes, O.D.

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Last Name____________________First Name_____________M.I.____Nickname_____________Date__________________

Birth date_____________________Age________ ☐ Male ☐ Female Cell / Home Phone_____________________

Address ____________________________________ City ________________________ State _________Zip___________

Patient's or parent's employer ____ Work Phone _________________

Spouse or parent's name _______________________ Employer ____________________ Work Phone _________________

Person to contact in case of emergency ____ Phone _____________________

Hobbies or Special Activities (Check all that apply)

☐ Sports ☐ Shooting ☐ Golfing ☐ Arts and Crafts

☐ Woodworking ☐ Cards ☐ Other ____

Do you use a computer? ☐ Yes ☐ No Hours per day?____

Responsible Party

Name of person responsible for this account _____________________________ Relationship to patient _________________

Address ____ Home phone _________________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Insurance company ____ Benefits Phone #______________________

Name of insured ____ Relationship to patient _________________

Birth date ____________________ SS# or ID# __________________________ Group #_____________________________

Name of employer ____ Work phone ______________________

Do you have any additional insurance? ☐ Yes ☐ No If yes, please let us know.

Acknowledgment of Privacy Practices

I acknowledge I have been made aware of the privacy practices that protect my name and personal information. A copy has been offered to me.

Authorization & Release

I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor.

X____ ____________________

Signature of patient (or parent if minor) Date