



Mark H. Seipel, OD
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DATE: _____

Patient Information		
PLEASE PRINT		
(Last)	(First)	(M.I.)
Patient: _____		
Name you prefer to be called: _____		
Address: _____ Apt # _____		
City	State	Zip
Home () _____ Work () _____		
Cell Phone () _____		
Email _____		
Sex: F M Age _____ DOB ____/____/____		
Marital Status: Single Married Divorced Widowed		
Spouse's Name _____		
Race (Select one or more)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to answer	
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to answer		
Preferred Language _____		
Patient SS# _____ (For Insurance Purposes only)		
Occupation _____		
Employer _____		
IN CASE OF EMERGENCY, CONTACT		
Name: _____		
Relationship: _____		
Home # _____ Work # _____		
Cell# _____		

Responsible Party Information		
Name: _____		
Relationship: _____		
Address: _____		
City	State	Zip
Home () _____ Work () _____		
SS #: _____ (For Insurance Purposes Only)		
INSURANCE		
Primary Insurance: _____		
ID#: _____ Subscriber DOB: _____		
Subscriber Name: _____		
Subscriber SS # _____		
Secondary Insurance: _____		
ID#: _____ Subscriber DOB: _____		
Subscriber Name: _____		
Subscriber SS # _____		
How did you hear about our office? (Circle One)		
Family Member	Friend	Doctor Referral
Office Website	Newspaper	Insurance Carrier
Location	Internet Search	Yellow Pages
Who may we thank for referring you to our office? _____		
<p>I hereby authorize any necessary treatment by the Optometrists in the practice of Drs. Seipel, Dragon & Jason and further authorize Drs. Seipel, Dragon & Jason to file a claim with my insurance (s) providing I have coverage for the services rendered. I understand that I am responsible for my bill and any collection fees made necessary to collect payment of services and/or products provided in the event that I do not have the required coverage or the insurance claim is denied. I further authorize the office of Drs Seipel, Dragon & Jason to release or obtain any required medical information from my attending physicians or any medical facility.</p>		
Patient Signature _____ (If MINOR, a parent/guardian MUST sign)		
Date _____		