Curtis R. Anderson, O.D.
Darrel D. Smith, O.D.
932 Massachusetts Street
Lawrence KS 66044
785.843.8200
785.843.8262 fax
OM #_____ (office use)

Date_____

Name_____/_____/_____
Last First Middle

Preferred Name_____ Title: Mr. Mrs. Miss Ms. Dr.

Address_____

City_____State_____Zip_____

Phones: Home (____)_____ Work (____)_____ Cell (____)_____

Date of Birth_____ Age_____ Gender M F

Occupation_____ Employed By _____

Spouse_____

Parents (if under 18)_____(or person responsible for payment if other than above)

Address_____City_____State_____Zip_____

Employed by_____

FULL PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Method of Payment: Cash/Check____ Visa/MC/Discover____

Insurance: Medicaid____ Medicare_____
BC/BS_____ Superior _____
VSP _____ Other_____

Referred by_____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination and to process my insurance claim. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

I acknowledge that a copy of the Notice of Privacy Practices is available upon request from Curtis R. Anderson, O.D. and Darrel D. Smith, O.D.

My information may be shared with the following people: (spouse, parent, children, other-print names below)

_____

Patient's Signature_____(or guardian) (03/08)