Curtis R. Anderson, O.D.
Doctor of Optometry
932 Massachusetts Street, Lawrence, KS 66044

Date_______________

Patient Name____
(Last) (First) (M.I.)

Preferred Name______________ **Prefix (please circle):** Mr. / Mrs. / Miss / Ms. / Dr.

Address____
(Street) (City) (State) (Zip)

Date of Birth________________ **Age**_____

For the following questions please circle:
Marital Status: Single / Divorced / Widowed / Married- Spouse's Name________________ / Other
Employment: Occupation_______________________ Employed by_______________________ ***OR***
Retired / Full-Time Student / Part-Time Student / Other_____________
Gender: Male / Female
Last 4 digits of Social Security #: _________
Race: American Indian / Asian / Black or African American / White / Prefer not to say
Preferred Language: English / Other_____________
Cultural Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Prefer not to say

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Phone Numbers: Home________________ Cell________________ Work________________
Where do you prefer to receive calls? (please circle): Home / Cell / Work
Email_____________________________

Who is responsible for payment? (please circle): Self / Spouse / Parent
Name___________________ Address_____________________________ Phone________________

Emergency Contact:
Name_____________________ Relationship__________________ Phone________________
I would like my health and vision information available to the following friends or family members:

________________________ ________________________________ _____________________________
________________________ ________________________________ _____________________________

PLEASE CONTINUE ON BACK SIDE

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Curtis R. Anderson, O.D. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

(CHOOSE ONE)

- ☐ I have read or had explained to me Curtis R. Anderson, O.D.'s Notice of Privacy Practice and agree to continue my care with Curtis R. Anderson, O.D. under said terms.

- ☐ I was given the opportunity to read Curtis R. Anderson, O.D.'s Notice of Privacy Practices and declined but wish to continue my care with Curtis R. Anderson, O.D. under the terms of Curtis R. Anderson, O.D.'s privacy policies.

- ☐ I have read or had explained to me Curtis R. Anderson, O.D.'s Notice of Privacy Practice and do not wish to continue my care with Curtis R. Anderson, O.D. under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as:

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____________________________________ __________________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

______________________________ _______________________

Representative Relationship to Patient

E-PRESCRIBING & MEDICATION HISTORY CONSENT

- E-Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner.
- E-Prescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, reduces medication errors, and improves both the efficiency and effectiveness of your care.
- E-Prescribing software also lets your doctor see important information, such as drug interactions and your prescription history.

I agree that the office of Curtis R. Anderson, O.D. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature____ (or guardian)