Tashner Vision Clinic LLC

Date __________ Last Name ____________________ First _____________ Middle Int. ___ DOB __________

Address ______________________________________ City ________________ State _____ Zip__________

Home Phone ___________________ Cell Phone ____________________ Work Phone __________________

Medical Insurance: ______________________________ Vision Insurance ______________________________

Primary Care Physician ____

Email Address ____

Release of Information

I authorize the release of my personal information to the following:

{ } Spouse _____________________ { } Child _____________________ { } Other _________________

{ } Information is not to be released to anyone.

Records Release

I authorize the release of all my records to/from Tashner Vision Clinic LLC at fax number 608-348-2574.

{ } To be released by my (Previous Provider): ____

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Patient Signature/Authorized Guardian

Notice of Privacy Practice / Signature-for file for Insurance filling

I acknowledge that I was offered and or received a copy of Tashner Vision Clinic, LLC, notice of privacy practice.

Signature ____ Date ______________________

PAYMENT DUE IN FULL AT TIME OF SERVICE

A 50% FEE WILL BE CHARGED FOR ALL CANCELLED ORDERS.