

**Dr. Traer Caywood, Dr. Rick Winward & Dr. Tim Seiter**  
**Utah Valley Optometric Physicians, LLC**

**Personal Information – Please Print Clearly**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender:  Male  Female  
Prefix:  Mr.  Mrs.  Ms.  Dr. Preferred Name: \_\_\_\_\_  
Marital Status:  Married  Single  Other Preferred Language: \_\_\_\_\_ SS#: \_\_\_\_\_

**Employment Status:**  Retired  Employed  Full-time student  Part-time student  Minor  Homemaker

**Race/Ethnicity:**  American Indian or Alaska Native  Asian  Black or African American  Hispanic  Native Hawaiian or other Pacific Islander  White or Caucasian

**Personal Health Info Release:** I authorize the following to receive any medical documents or materials on my behalf

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_ Tertiary: \_\_\_\_\_

**Contact Information:** (By including your email, you agree to receive appointment reminders, newsletters, social media, and promotions from our office.)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Preferred method of contact:  phone  work  cell  text  email

**Please tell us how you were referred to our office:**  Insurance Panel  Phonebook  Website  Daily Universe  Facebook  
 School  Internet Search  Doctor's Clinic \_\_\_\_\_  Individual: \_\_\_\_\_

**Relationship Information/Policy Holder:**

Responsible Person: \_\_\_\_\_ Patient's Relationship to Person:  Self  Spouse  Child  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Medical Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy/SS#: \_\_\_\_\_ Policy/SS#: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_ Employer of Insured: \_\_\_\_\_

**Please Read and Sign Below:**

Payment for all medical services is the responsibility of the patient and is expected at the time of service.

I agree to pay all attorney fees, court costs, and filing fees, including charges or commissions up to 50% that may be assessed to me by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of one and one half percent per month (18% per year). I understand there is a \$25.00 service charge for all returned checks.

I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to provider of facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be released to anyone else without my written consent.

I hereby authorize any procedures, including dilation of the eyes, as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.

**Acknowledgement of Receipt:**

I acknowledge that I received the following policies from the office of Drs. Caywood, Winward, and Seiter:

Notice of Privacy Practice  Financial Responsibility Information  Understanding Insurance

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
Signature of patient or legal guardian Print Name Today's Date