PATIENT INFORMATION

1. Patient Name____ Date____________

2. Phyxical Address ____
Street City State Zip

3. Mailing Address if different ____

4. Date of Birth__________Age______Male/Female_______Social Security # ____________________

5. Telephone(Work) ________________Telephone(Home)____________ Cell ______________

6. Email Address ____

7. Employer ____

Address/Phone ____

Please circle Single Married Widowed Divorced

8. Name of referring physician________________Name of family physician ________________

9. Is this a workers compensation injury? If yes, list employer, address and supervisor authorizing treatment.

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10. Is your visit today for a routine eye examination? Yes No
If yes, are you covered by a vision plan? If so, please provide the vision plan information.

Vision Plan________________________
Subscriber's Name________________ Subscriber's Date of Birth_______ Subscriber's SS#__________

Primary Medcical Insurance ______________________ ID#______________ Group #______

Subscriber's Name ________________ Subscriber's Date of Birth _______ Relationship to patient ______

SecondaryMedical Insurance ______________________ ID# ______________ Group # _______

Subscriber's Name________________Subscriber's Date of Birth_______Relationship to patient ______

11. Whom to notify in emergency? (nearest relative)

Name______________________Relationship______________ Home Phone____________

Address____Work Phone____________

12. Complete if under 18 years of age or student
Name of Father______________Date of Birth__________Social Security #________________
Employer/Address/Phone ____
Name of Mother______________Date of Birth__________Social Security #________________
Employer/Address/Phone ____

Authorization to release information

I hereby authorize the above doctor/doctors to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of insurance benefits

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. I understand I am financially responsible to said doctor for charges.

____ ___________________________

Responsible Party's Signature **Date**