PATIENT INFORMATION

1. Patient Name_____ **Date**_____

2. Address _____

Street **City** **State** **Zip**

3. Date of Birth_____**Age**_____**Male/Female**_____**Social Security #**_____

4. Telephone (Work) _____**Telephone (Home)**_____ **Cell** _____

5. Occupation_____**Employer**_____

Address/Phone_____

Please circle: **Single** **Married** **Widowed** **Divorced**

6. 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 _____

7. Name of referring physician_____**Name of family physician** _____

8. Are you personally responsible for the payment of your fees? Yes No If no, who is?_____

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

_____

10. Is any part of your eye examination covered by insurance? Yes No

If yes, by whom are you covered?

Primary Insurance _____ **ID#**_____ **Group #**_____

Subscriber's Name _____ **Subscriber's Date of Birth** _____ **Relationship to patient** _____

Secondary 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**_____

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**