

## Patient Information

Name: MR. MRS. MISS MS.		FIRST	MIDDLE	LAST	Today's Date:
Home Phone:			Social Security #: - -		
Work Phone:			Birth Date: / /		Age:
Cell / Pager / Other:			Gender: M F		Marital Status: Single Divorced Married Widowed
E-Mail:			Occupation:		
Address:		Apt.		Employer:	
City:	State:	Zip:			
Emergency Contact:			Special Needs:		
Phone:			<input type="checkbox"/> Hearing-impaired <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Other: _____ <input type="checkbox"/> Translator    Language: _____		
Relationship to patient:					
<b>PRIMARY Insurance:</b>			<b>Patient is the policy subscriber / guarantor:</b>		
ID / Policy #:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>SECONDARY Insurance:</b>					
ID / Policy #:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>VISION / OPTICAL Insurance:</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If policy subscriber / guarantor is other than the patient:</b>					
Name:			Social Security #: - -		
Phone:			Birth Date: / /		
Relationship to patient:			Employer:		
Family / Primary Physician:			Phone:		

**How did you hear about our practice?**     MD / DO \_\_\_\_\_     Optometrist (OD) \_\_\_\_\_

Friend / Family     Patient     Yellow Pages     Newspaper     Sign     Radio     Other \_\_\_\_\_

**I am interested in learning more about the following available services:**

Refractive Eye Surgery (LASIK, etc.)     Botox Wrinkle Relaxer     Cosmetic / Aesthetic Services

I authorize the release of any medical information necessary to process all claims, including Medigap. I also authorize the release of payment of medical benefits to my physician. If my insurance denies the claims, I agree to be financially responsible for my bill.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_