

Date: \_\_\_/\_\_\_/\_\_\_  
M D 20XX

Patient #: \_\_\_\_\_

Name: \_\_\_\_\_  
First M Last

Gender:  Male  Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_  
M D XXXX

Address: \_\_\_\_\_  
Street address 1

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street address 2  
City State ZIP

Employed  Student  Retired  Minor

Single  Married  Widowed

Home Phone: (\_\_\_) \_\_\_ - \_\_\_

Employer: \_\_\_\_\_

Work Phone: (\_\_\_) \_\_\_ - \_\_\_

Occupation: \_\_\_\_\_

Cell Phone: (\_\_\_) \_\_\_ - \_\_\_

email: \_\_\_\_\_

Fax: (\_\_\_) \_\_\_ - \_\_\_

Emergency Information: Phone: (\_\_\_) \_\_\_ - \_\_\_

Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

**-Please complete for our records-**

REFERRING OPTOMETRIST: \_\_\_\_\_ Phone: (\_\_\_) \_\_\_ - \_\_\_

REFERRING MD: \_\_\_\_\_ Phone: (\_\_\_) \_\_\_ - \_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_) \_\_\_ - \_\_\_

If other than physician referral please check the one that better applies how you heard of us

- Relative / Friend  Yellow Pages  Employer  Newspaper Ad  Direct mail  Radio  
 TV  Ins. Co.  Internet  Newsletter  Seminar/Lecture  Other \_\_\_\_\_

Place of Seminar \_\_\_\_\_ Name of Relative or Friend \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: PRIMARY  PPO  HMO

SECONDARY  PPO  HMO

Name of Insurance: \_\_\_\_\_

\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_  
(AS IT APPEARARS ON CARD)

\_\_\_\_\_  
(AS IT APPEARARS ON CARD)

Policy Holder's: Social Security # (SSN): \_\_\_ - \_\_\_ - \_\_\_

Social Security # (SSN): \_\_\_ - \_\_\_ - \_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_  
M D XXXX

Date of Birth: \_\_\_/\_\_\_/\_\_\_  
M D XXXX

Policy ID # \_\_\_\_\_

Policy ID # \_\_\_\_\_

Effective Date: \_\_\_/\_\_\_/\_\_\_  
M D XXXX

Effective Date: \_\_\_/\_\_\_/\_\_\_  
M D XXXX

**PATIENT'S OR AUTHORIZED SIGNATURE:** I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits and/or medical insurance benefits either to myself or to the party who accepts assignment.

**For Minors:** I give my permission for my child to be treated by  Dr. Stephen E. Smith  Dr. Paul R. Brown  
 Dr. Brenda J. Polewac  Dr. John Nassif  Dr. Donna Mangatt

\_\_\_\_\_  
Patient/Guardian Signature

DATE: \_\_\_/\_\_\_/\_\_\_  
M D 20XX

**- Please turn page for additional information -**

