

Patient Information

Chart # _____

Patient Name _____
Last First MI Title

Address _____
Street or P O Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

M F Birthdate _____ Social Security Number _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient's/Parent's employer _____ Occupation: _____

Spouse/Parent's name _____ Employer _____ Occupation _____

If patient is a student, name of school/college _____ Teacher: _____

Person to contact in case of emergency _____ Phone _____

How did you hear of our office: _____

If someone referred you, please indicate name: _____

May we use your name in thanking this person? Yes No

Responsible Party

_____ Title _____ Relationship to Patient _____
Last First MI

Address _____ Home Phone _____
Street or P O Box City State Zip

Work Phone _____ Social Security # _____ Name of employer _____

M F Birthdate _____ Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Name of employer _____

Insurance company _____ Subscriber number _____ Group # _____

Do you have a vision rider? Yes No Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Name of employer _____

Insurance company _____ Subscriber number _____ Group # _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefit. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X

Signature of patient or parent, if minor

Date