

Date	Account ID	Chart ID	Other II)	Internal Use		
Patient Informati	on						
Name Last:		First :	<u> </u>	ИI:	Gender: M F		
Marital Status:		DOB: / /	Age:	E-mail:			
Address:		City:		State:	Zip Code:		
Phone: Home		Cell:			Work:		
Emergency Contact:		Phone:			Relationship:		
mployer Name:		Employer Address:		Occupation:			
Patient Social Security Number:		Spouse (or Parer		s) Name:			
Purpose of this visit or	vision problems, i.e.	. vision change, contac	ct lenses/new g	glasses:			
Physician:		Family Physician:		Referring Physician:			
referred Pharmacy Name:		Address:		Phone:			
Communication Prefere	nce: Phone E	-mail: Texting May	we use the en	nail provided	for this communication	?	
Medical Insurance	2						
1).Primary Medical Insu	rance Name:						
Policy Holder Name:			Policy	Holder's DOE	3: / /		
Relationship:		Men	nber ID:		Group ID:		
2).Vision Insurance Nan	ne:						
Policy Holder Name:			Policy	Holder's DOE	3: / /		
Relationship:		Men	mber ID:		Group ID:		
Guarantor (Perso	n to be billed,	if different than	patient)				
1). Name Last:	First:	MI: C	Gender: M F	Marital Sta	tus: DOB: / /	/ Age:	
Address:		City:		State:	Zip Code:		
Phone Home:	Cell:		Work:		E-mail:		
Employer Name:		Employer Address:			Occupation:		
Very Important!	New Patients O	nly:					
How did you hear of us	::	Who may we	thank for refe	rring you to c	our office:	· · · · · · · · · · · · · · · · · · ·	
If not referred, how did	l you choose our off	fice: Another Dr. 🗌	Insurance List	t Social N	Media 🗌 In the Area/L	ocation	
ervices rendered. I under	authorization to treat stand that I am ultimat tor to release all inforn	and assign directly to Sha ely financially responsible nation necessary to secur	e for all approved re the payment o	d and covered o	nefits, if any, otherwise paya charges whether or not pai thorize the use of this signa	d by insura	
l acknowledge receipt of t purposes to treating me, o					close my health informatio erations.	n for	
Signature:			Date:				