



Patient Information

Name: _____ Date: _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Employer Phone: (____) _____

Employer Address: _____
Street City State Zip

Birth Date: ____/____/____ SS#: ____-____-____ **Circle:** Male - Female | Single - *Married - Divorced - Widowed

* Used For Family Accounts *

Spouse Name: _____ Spouse Birth Date: ____/____/____

Name of family member **not** currently living with you: _____

Phone Number: (____) _____

Did anyone refer you to our practice? _____

Your primary care physician _____ Phone Number: (____) _____

Financially Responsible Party Information:

Who is the financially responsible party? Self _____ Spouse _____ Parent _____

Please complete the following, if other than the patient is financially responsible.

Name: _____ Home Phone: (____) _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____
Street City State Zip

Birth date: ____/____/____ Social Security #: ____-____-____ **Circle:** Male - Female _

Employer: _____ Employer Phone: (____) _____

Employer Address: _____
Street City State Zip

Disclosure Information

It is our policy to contact you by phone regarding upcoming appointments or product pickup. If you are unavailable, a message will be left stating the arrival of your product or the date and time of your appointment. A cell phone is not a secure and private line. Your signature below will be viewed as permission to leave a message on your answering machine or cell phone (Patient Signature) _____

To whom we may disclose your medical/optical treatment and account information:

(1) Name: _____ Relationship: _____

Phone:(____) _____

(2) Name: _____ Relationship: _____

Phone:(____) _____

Please complete both sides of this form completely and return to front desk.

For Office Use Only:

ACCT # _____

PT# _____