

PATIENT INFORMATION

Name: _____ Age: _____
Last First Middle

Date of birth: ____/____/____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Work/other#: (____) _____

Sex: (circle one) M F

Social Security#: _____

Who referred you to this office? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Home #: (____) _____

Relationship to patient: _____

I/or my representative, hereby authorize the doctor to release information related to this claim and I authorize payment of this claim directly to the doctor. I realize that my eyes will be dilated for this examination and my vision may be blurry for several hours. Walking and driving is at my own risk.

Signature: _____ Date: _____
(insured or authorized person)

Please Return To Office