Date: ____________________

Patient Information Form

GENERAL INFORMATION

Name (First, MI, Last) ____ Preferred Name: __________________________

Street Address____ City____________________ State_______ Zip___________

Home Phone__________________ Cell Phone_________________ Email Address ____________________________________

Preferred Contact Method: cell phone / email / text / home phone / other (please explain) ____________________

Date of Birth___________________ Male / Female Language, Race, Ethnicity ___________________________________

Employer (or School)____ Occupation (or Grade)_________________________

Emergency Contact Person and Phone ____

If you are a new patient, how did you hear about us?____

Do you currently wear glasses? Yes / No Do you currently wear contact lenses? Yes (Brand___________________) / No

Name of primary physician____________________________________

Pharmacy _____________________________________ Are you pregnant or nursing? _____________

CONSENT TO TREATMENT

I hereby grant MY authorization and consent for medical treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as to the results which may be obtained. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or health practitioners. I authorize the eye doctor to obtain and view my medication history via electronic database or from my pharmacy or doctor's office. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_______________________________ _______________________________ ____________________

Signature of patient or Guarantor **Relationship if not patient** **Date**