PLEASE COMPLETE BOTH SIDES

PATIENT INFORMATION FORM

Last Name ______________ First Name ______________ Middle ________

Address ______________ Email ______________

City ________ State ______ Zip Code ______ Home Phone ________

Work Phone ______________ Sex M____ F____ Age ______ Birth Date ________

Marital Status Circle One: Single Married Divorced Widowed

PRIMARY CARE PHYSICIAN

Name Of Doctor ______________

Address ______________

City ________ State ______ Zip ______

Phone Number ______________ Fax Number ______________

VISION INSURANCE - NAME ______________ (e.g.) (Eyemed, NVA, Optum Health)

I.D. Number ______________

Subscriber ______________ Birth Date ________ Social Security # ________

Relationship To Insured: Circle One: Self Spouse Child

PRIMARY MEDICAL INSURANCE - NAME ______________ (e.g.) Keystone, Personal Choice, Blue Shield, Aetna)

I.D. Number ______________

Subscriber ______________ Birth Date ________ Social Security # ________

Relationship To Insured: Circle One: Self Spouse Child

Signature on File/Authorization/Assignment

I request that payment of authorized Medicare, Medigap and/or Insurance benefits be made payable on my behalf to Dr. Patel for any services furnished to me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and is agent any information needed to determine these benefits payable for related services.

I hereby authorize Dr Patel to furnish information to Insurance carriers concering my illness and treatments and I hereby assign to physician all payments for medical services rendered to my or to my dependent. I understand that I am responsible for any amount not covered by insurance.

Date: ______________ Signature: ______________

OVER

eye color ________

Occupation ________