PATIENT INFORMATION

DATE: ___________

Last Name________________ First Name______________________ Middle Initial________

Address__________________________ City_________________________________ State________ Zip_________

Home Phone____________________________ Cell or Alternate Phone_______________________________

Date of Birth____________ Age: ____Social Security No:_____________________ Marital Status_____________

Email____ Family Physician______________________________________

Do you wear glasses yes___ No___ Do you wear contacts yes____ No____
Are you interested in contact lenses Yes____ No_____

PATIENT EMPLOYER/PLACE OF EMPLOYMENT:

Employer______________________________ Occupation______________________________

Employer Address____

RESPONSIBLE PARTY (if patient is under 18 years of age):

Last Name______________ First Name_________________ Relation_________________

Address_____________________ City_______________________ State________ Zip__________

Home Phone______________________ Cell or Work Phone_______________________________

Medical Insurance:

Insurance Name________________ policy/ID #______________________ Group #_____________________

Insured Name____________________ Date of Birth____________ Relation________ S.S. #______________

Insured Employer/Group Name___________________________ Phone number______________________

Vision Insurance:

Name of Vision Insurance________________________________

The Above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process this bill to my Insurance company, and request payment of benefits to be paid to Dr. Barry P. August, I acknowledge that I am financially responsible any balance (deductibles, coinsurance, copays, and non-covered services) my insurance determines is my responsibility.

Patient Signature/Guardian Signature Date____