Gregory J. Pamel, M.D.
Michael J. Newton, M.D., P.C.
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Lauren Lanigan, O.D., F.A.A.O.

PAMEL VISION & LASER GROUP

Welcome To Our Office

◊ PATIENT INFORMATION ◊

Date _____

Name _____ **SS#** _____-_____-_____
Last Name First name Initial

Address _____ **Apt** _____

City _____ **State** _____ **Zip code** _____

Age _____ **Date of birth:** _____ **Email:** _____

☐ Single ☐ Married ☐ DP ☐ Widowed ☐ Separated ☐ Divorced **Sex ☐ M ☐ F**

Patient Employed by: _____ **Occupation:** _____

Home Phone_____ **Business Phone** _____

Cell Phone _____

In case of emergency who should we notify?

Name:_____ **Telephone:** _____

◊ PRIMARY INSURANCE ◊

Person Responsible for Payment of Account ☐ Self ☐Other _____

Relation to Patient _____ **Birthdate** _____

PRIMARY Name on Insurance Policy _____ **Policy #** _____

☐ Medicare _____ **☐Other Insurance** _____

Does your insurance require a REFERRAL from your primary care physician to see us?
☐No ☐Yes * Please give REFERRAL to front desk attendant

◊ ADDITIONAL INFORMATION ◊

How did you find out about our office? *Please specify*

☐Referring physician _____ **☐Family/Friend** _____
☐Website _____ **☐TV/Radio/Magazine** _____
☐Insurance Directory _____ **☐Internet – Search Engine** _____
Other _____-_____

◊ ASSIGNMENT AND RELEASE ◊

I, Undersigned certify that I (or my dependent) have insurance coverage with _____ and assign all insurance benefits to _____
If any, otherwise payable to me for services rendered. Understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the named doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

What eye condition are you being examined for today?

_____

_____

_____

PHARMACY NAME & TELEPHONE NUMBER:

_____

_____

Are you interested in:

- ☐ *LASIK/VISION CORRECTION*
- ☐ *BOTOX® for wrinkles and facial shaping*
- ☐ *FACIAL FILLERS*
- ☐ *LATISSE® FOR EYELASHES*
- ☐ *EYELASH SERUM*
- ☐ *TEOXANE*