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### Welcome To Our Office

#### ◇ PATIENT INFORMATION ◇

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex  M  F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last Name                      First name                      Initial

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Age \_\_\_\_\_ Date of birth: \_\_\_\_\_ Email: \_\_\_\_\_

Single  Married  DP  Widowed  Separated  Divorced

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?

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PHARMACY NAME & TELEPHONE NUMBER:

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*Are you interested in:*

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