NORTHSHORE OPTOMETRY

PATIENT- INFORMATION:

Last Name: _____ First Name:_____

Sex:____ Date of Birth:_____SS#_____E-Mail:_____

Address:_____City:_____State: ____ Zip:_____

Employer:_____Marital Status: Single Married Divorced Widow

Home Phone: _____Cell:_____Work:_____

Please circle telephone number where we can best reach you or leave a message.

SPOUSE/RESPONSIBLE PARTY- INFORMATION:

Last Name:_____First Name:_____DOB:_____

SS#_____Employer:_____

Primary Insurance:_____Secondary Insurance:_____

Emergency Contact:_____ Phone:_____

Family Doctor:_____
Pharmacy:_____

Assignment & Release: *I hereby assign benefits to be paid directly to Northshore Optometry. I am financially responsible for all NON-COVERED services. I also authorize the doctor to release information to process my claim to my employer or insurance company.*

_____

signature of patient or parent if minor *date*

I give permission for my medical information or test results to be released to the following people:

1. _____Relationship:_____

2._____ Relationship:_____

3. _____ Relationship:_____

Can we leave a message on your answering machine? Y/N