PATIENT INFORMATION

PLEASE PRINT:

1. NAME:_____ M_____ F_____

2. ADDRESS:_____
   Street City State Zip

3. DATE OF BIRTH:_____ AGE:_____ S.S. #_____

4. TELEPHONE: (home)_____ (cell)_____

5. E-MAIL ADDRESS _____

6. OCCUPATION_____ EMPLOYER_____

7. NAME OF SPOUSE_____ S.S. #_____ D.O.B.: _____

   SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED_____

8. PERSON TO CONTACT IN CASE OF EMERGENCY:

   NAME: _____ TELEPHONE: _____

   ADDRESS: _____ RELATIONSHIP: _____

9. NAME OF REFERRING DOCTOR OR PERSON_____

   NAME OF FAMILY DOCTOR_____

10. PLEASE LIST YOUR MEDICAL INSURANCE_____

    DO YOU HAVE VISION COVERAGE: YES_____NO_____ IF SO - LIST_____

MEDICARE PATIENTS: "I authorize any holder of medical or other information about me to be released to the Social Security Administration and health care financing administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment." I understand that some procedures performed in this office may not be covered by Medicare and will be my responsibility.

_____ **DATE:**_____

MEDICARE PATIENTS SIGNATURE (Parent or Guardian, if patient is a minor)

CONSENT FOR EXAM & TREATMENT

I the undersigned, hereby authorize my physician or the physician assigned, his/her assistants or designees and Great Lakes Eye Institute to furnish medical exam, treatment, routine diagnostic procedures and therapies. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the results of this care & treatment which I have authorized.

SIGNATURE_____ **DATE:**_____

Patient (Parent or Guardian, if patient is a minor)

ASSIGNMENT OF BENEFITS FOR PHYSICIAN SERVICES

I assign all rights to benefits, insurance proceeds, settlement payments or judgements to which I may be entitled for doctor's services in connection with the interpretation of laboratory, diagnostic tests, exam, to the doctor or organization furnishing the services and/or such doctor or organization to submit a claim for payment on my behalf to insurance.

I agree to pay any amounts that are not covered by my insurance.

The above has been explained to me and that I understand them.

SIGNATURE_____ **DATE:**_____

Patient (Parent or Guardian, if patient is a minor)