

# WELCOME TO OUR OFFICE

## PERSONAL

DATE \_\_\_\_\_

PATIENT NAME Mr. Mrs. Ms. Dr. \_\_\_\_\_  
(Please circle one) (LAST) (FIRST) (Middle Initial)

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RES TEL (\_\_\_\_) \_\_\_\_\_ BUS TEL (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SS# \_\_\_\_\_

YOUR PRIMARY CARE PHYSICIAN \_\_\_\_\_

LAST EYE EXAM \_\_\_\_\_ DO YOU WEAR CONTACTS? \_\_\_\_\_ ARE YOU INTERESTED IN CONTACT LENSES? \_\_\_\_\_

ARE YOU INTERESTED IN LEARNING ABOUT LASER VISION CORRECTION? \_\_\_\_\_

## REFERRAL INFORMATION

How did you learn about our office? (Please circle the sources that apply)

Relative Friend Yellow Pages Sign Doctor Referral Insurance Previous Patient Other

If you are a new patient whom may we thank for referring you to our office? \_\_\_\_\_

## INSURANCE INFORMATION

INSURANCE CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_

INSURED NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

INSURED SS# \_\_\_\_\_ INSURED'S DATE OF BIRTH \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF MEDICAL OR GOVERNMENT BENEFITS, INCLUDING MEDICARE, TO DR. HANLEY FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ANY UNMET DEDUCTIBLE, COPAYMENT AND NON-COVERED INSURANCE FEES

 \_\_\_\_\_

## Receipt of Notice of Privacy Practices Written Acknowledgement

I, \_\_\_\_\_, have reviewed/received a copy of Craig Hanley, O.D. 's  
(please print name) Notice of Privacy Practices.\_\_\_\_\_  
Signature of Patient/Guardian Date

Updated Date \_\_\_\_\_ Initials \_\_\_\_\_ Updated Date \_\_\_\_\_ Initials \_\_\_\_\_ Updated Date \_\_\_\_\_ Initials \_\_\_\_\_