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_____MARITALSTATUS_____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#_____INSUREDS 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

X_____

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 _____