

Doctor: _____
 Location: _____
 I.D. #: _____
 Pref. Location: _____

**PATIENT INFORMATION SHEET
 (PLEASE PRINT)**

PATIENT NAME:	<input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Mr <input type="checkbox"/> Dr		
		<i>(Last)</i> _____	<i>(First)</i> _____ <i>(MI)</i> _____
PREFERRED NAME OR NICKNAME (such as "Johnny", "Mrs. Smith" or "Dr. Jones"):		_____	
ADDRESS:	_____		
	<i>(Street)</i>	<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
HOME PHONE: ()	AGE:	BIRTHDATE:	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
CELL PHONE: ()	SOCIAL SECURITY #:		
E-MAIL ADDRESS:			
EMPLOYER:		WORK PHONE #: ()	
EMPLOYER ADDRESS:		OCCUPATION:	
SPOUSE'S NAME: <i>(If minor, parent's name)</i>		SPOUSE'S <i>(or parent)</i> SS #:	SPOUSE'S <i>(or parent)</i> DOB:
HOW DID YOU HEAR ABOUT THIS OFFICE: <i>(Please check all those that apply)</i> <input type="checkbox"/> Family Member. If so, who _____ Relationship to you: _____ <input type="checkbox"/> Friend. If so, who _____ <input type="checkbox"/> Doctor referral. If so, who? _____ Location? _____ <input type="checkbox"/> Newspaper <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Screening <input type="checkbox"/> Self <input type="checkbox"/> Billboard <input type="checkbox"/> Internet <input type="checkbox"/> Other _____			
FAMILY PHYSICIAN:		LOCATION:	
NEAREST RELATIVE NOT LIVING WITH YOU or EMERGENCY CONTACT:		PHONE #: ()	RELATIONSHIP:
ADDRESS:			
INSURANCE POLICY HOLDER NAME & DATE OF BIRTH (if not the patient). We must have this information to file your claim:			

I do not authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results and/or treatment with anyone other than myself or my insurance carrier.

INSURANCE AUTHORIZATION AND AGREEMENT

I hereby authorize Bennett & Bloom Eye Centers to furnish information to insurance carriers concerning my illness and I hereby assign to the doctor all payments for medical services to myself or my dependents.

I understand I am responsible for deductibles, co-pays, non-covered services, coinsurance and items not covered by my insurance company and all fees associated with collection of these amounts.

Signature: _____

Date: _____ By: _____

Updated: _____ By: _____

Updated: _____ By: _____

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Internal Use Only

Ins. Copied ___ Other ___ No Ins ___ Initials _____