WELCOME TO OUR OFFICE

PERSONAL INFORMATION

DATE_____

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

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

CELL (____)_____ RES TEL (_____) _____

E-MAIL ADDRESS (this is for appointment reminders)_____

LANGUAGE _____ DATE OF BIRTH_____ MARITALSTATUS_____

LAST EYE EXAM_____DO YOU WEAR CONTACTS? _____ARE YOU INTERESTED IN CONTACT LENSES? _____

HOW DO YOU PREFER TO BE CONTACTED (PLEASE CIRCLE ONE):

EMAIL PHONE MAIL

REFERRAL INFORMATION

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

Relative Friend Sign Doctor Referral Insurance Previous Patient Other

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

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have reviewed/received a copy of Dr. Hanley's **Notice of Privacy Practices**
(Please print name)

X _____ _____
(Signature of Patient/Guardian) Date

INSURANCE INFORMATION (If Applicable)

VISION INS_____ ID#_____ INSURED NAME _____

RELATIONSHIP TO INSURED _____INSURED'S DATE OF BIRTH_____

MEDICAL INS_____ ID#_____ INSURED NAME _____

RELATIONSHIP TO INSURED _____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

X_____