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 (_____) ______________ BUS TEL (_____) ______________RES TEL (____)______________

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

LANGUAGE ________________ DATE OF BIRTH______________ MARITAL STATUS__________

LAST EYE EXAM__________DO YOU WEAR CONTACTS? ______ARE YOU INTERESTED IN CONTACT LENSES? ________

HOW DO YOU PREFER TO BE CONTACTED (**PLEASE CIRCLE**)

TEXT EMAIL CELL RES TEL 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**
(Print Name) .

X ______________________________ ______________________________
(Signature of Patient/Guardian) Date

INSURANCE INFORMATION (If Applicable)

INSURANCE PLAN____

INSURED NAME______________________________RELATIONSHIP TO INSURED______________

INSURED ID#______________________________ 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____