

NEW PATIENT INFORMATION

Welcome to our office. You will find that we are truly committed to helping all of our patients to improve their vision by providing state of the art eye care in a warm and friendly environment. To verify that we have all of the information needed to properly set up your patient file, we ask you to provide the following information.

Name _____ DOB _____ Sex _____
Address _____ City _____ State _____ Zip _____
Phone numbers Home _____
Work _____
Cell _____
Email address _____ SS# _____ DL# _____
Employer Name _____
Patients Occupation _____

Responsible party _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____

HIPAA certification. In accordance with federal law I have seen the HIPAA policies of this office and I acknowledge them.

Signature _____ date _____

Please return this form to the receptionist when you are finished.