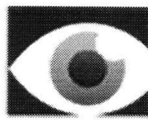

EYEDOCDULLES

Dr. Joanna M Barnett & Associates Inc

PATIENT'S NAME: LAST FIRST MIDDLE	**DATE OF BIRTH:** / / **SSN#** - -
HOME/MAILING ADDRESS: CITY	**STATE ZIP CODE**
GENDER (PLEASE CIRCLE ONE): *FEMALE MALE*	**CELL PHONE NUMBER:**
OCCUPATION:	**BEST WAY TO CONTACT YOU (PLEASE CHECK ONE):** O PHONE O EMAIL
HOW WERE YOU REFERRED TO US? (PLEASE CHECK ONE): O *SOCIAL MEDIA* O *FRIEND/FAMILY* O *OTHER*________	**NAME OF YOUR PRIMARY CARE PHYSICIAN:**
MINOR'S LEGAL GUARDIAN: NAME: DOB: / / SSN#: - -	**MINOR'S LEGAL GUARDIAN:** NAME: DOB: / / SSN#: - -
MARITAL STATUS (PLEASE CIRCLE ONE): *SINGLE MARRIED SEPARATED DIVORCED WIDOWED*	**EMAIL ADDRESS:**________________

VISION INSURANCE	**MEDICAL INSURANCE**
NAME OF POLICY HOLDER: LAST FIRST MIDDLE **DATE OF BIRTH:** / / **GENDER (PLEASE CIRCLE)** ***FEMALE MALE*** **RELATIONSHIP WITH PATIENT:**	**NAME OF POLICY HOLDER:** LAST FIRST MIDDLE **DATE OF BIRTH:** / / **GENDER (PLEASE CIRCLE)** ***FEMALE MALE*** **RELATIONSHIP WITH PATIENT:**
NAME OF *VISION* INSURANCE: POLICY ID: GROUP#:	**NAME OF *MEDICAL* INSURANCE:** POLICY ID: GROUP#:
HOME/MAILING ADDRESS OF *POLICY HOLDER*:	**HOME/MAILING ADDRESS OF *POLICY HOLDER*:**
HOME PHONE NUMBER OF POLICY HOLDER:	**HOME PHONE NUMBER OF POLICY HOLDER:**
EMPLOYER OF *POLICY HOLDER:*	**EMPLOYER OF *POLICY HOLDER:***

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to EYEDOCDULLES to render needed treatment to the above named.
2. Permission is granted to EYEDOCDULLES to release information regarding medical treatment, rendered to the above named patient to any insurance company, employer or referring physician.
3. **Managed Health Care Plans**: I understand that if I do not have vision coverage, or I am not eligible for a vision exam, I am responsible for a referral from my primary care physician. I understand that medical exams without a referral are my financial responsibility.
4. **I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.**
5. I understand that a charge of **$75.00** may be issued if I do not **cancel or make changes** to my appointment **24-48 hrs** prior to my appointment.

______________________ ____/____/____ ______________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **Date** **FRONT DESK/ WITNESS SIGNATURE**