Date ______________________ Home Phone (____)_________________ Cell Phone (___)_____________________

PATIENT INFORMATION

Name____ SS/HIC/Patient ID_______________________

Last Name First Name Middle Initial

Address ____ E-mail _______________________________________

City ____ State _______________ Zip ____________________

Sex ___M ___ F Age ______ Birthdate _________________ __ Married __ Widowed __ Single __ Minor

__ Separated __ Divorced __ Partnered

Patient Employer/School ______________________________ Occupation __________________________________

Employer/School Address ______________________________ Employer/School Phone ________________________

Whom may we thank for referring you?____

What is your reason for visit?____ Last exam date ____________________

CONDITIONS ***Check conditions you have or have had in the past***

___ Blurred Vision ___ Double Vision ___ Floaters ___ Loss of Vision ___ Sensitivity to Light

___ Cataracts ___ Eye Infection ___ Glaucoma ___ Retinal Disease ___ Wear Contact Lenses

___ Crossed Eyes ___ Eye Injury ___ Headaches ___ Seeing Flashes Type of Lenses_____________

___ Diabetes ___ Eye Surgery ___ Hypertension ___ Seeing Halos Hours per Day_____________

Check if your blood relatives had any of the following:

Disease Relationship to you

___ Blindness ___________________________

___ Cataracts ___________________________

___ Diabetes ___________________________

___ Glaucoma ___________________________

ALLERGIES you have to medications or substances

____

Medications *List medications you currently are taking*

____

____

INSURANCE INFORMATION

Person Responsible for Account ____

Last Name First Name Middle Initial

Relation to Patient ___________________________ Birthdate________________ Soc Sec # _____________________

Address (if different from patients) ____ Phone _______________________

City ____ State____________ Zip______________________

Person Responsible Employed by_____________________________ Occupation________________________________

Business Address____ Business Phone___________________________

Insurance Company____

Contact #______________________________ Group #________________ Subscriber ID___________________________

AUTHORIZATIONS

I certify that I have insurance coverage with ___________________________________and assign directly to *Christopher Burt, OD, PC* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to *Christopher Burt, OD, PC* for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer and their agents any information needed to determine these benefits or benefits for related services.

____ ___________________________________

Signature of Beneficiary, Guardian or Personal Representative Date