PATIENT INFORMATION

I. HOWARD FINE, M.D. RICHARD S. HOFFMAN, M.D. MARK PACKER, M.D.

Patient Name (First) (MI) (Last)			By what name do you wish to be called?	[ ] Male [ ] Female
Address City State Zip				Email
Home Phone # ( )	Date of Birth Mo Day Yr	( ) Single ( ) Widowed ( ) Married ( ) Divorced	Social Security #	
Employer City				Work Phone # ( )
Spouse's Name	Spouse's Employer			Spouse's Social Security #
Name of Responsible Party (If other than self)	Employer of Responsible Party (if other than self)			Relationship to Patient
Address City State Zip			Phone # ( )	Social Security #
Emergency Contact NOT at Your Address	Phone # ( )		Primary Care Physician	

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of the Insured	Insured's DOB	Name of the Insured	Insured's DOB
Social Security or Policy #	Group #	Social Security or Policy #	Group #
Address of Insurance Co		Address of Insurance Co	
City State Zip		City State Zip	

Auto Accident? Yes or No	Date Occurred	Insurance Co.	Claim #
Workman's Comp? Yes or No	Date Occurred	Insurance Co.	Contact Person

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles. **Co-payments and insurance deductibles are expected when services are rendered unless other arrangements have been made in advance with our business office.**

I hereby authorize Drs. Fine, Hoffman and Packer to release medical information to my insurance carrier or my referring doctor. I further give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to anyone answering at my home telephone number or for the leaving of that information on my home answering machine.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered. I understand that I am responsible for any amount not covered by insurance.

Date_____ **Signature**_____

Patient Signature (or parent if patient is a minor)

**********HOW DID YOU HEAR ABOUT US?**********

Drs. Fine, Hoffman & Packer ask that you take a minute to complete this short questionnaire to tell them how you were referred to this office for eye care. Please circle only one:

My Physician/Optometrist referred me_____

Physician/Optometrist's name

A Friend (X31) **A Relative** (X33) **Newspaper ad**_____(X01/X02) **Radio ad**_____(X03) **TV ad** _____(X04)

Name of Paper Station Name Station Name

Yellow pages (X39) **Emergency/On Call** (X28) **Insurance List** (X11) **Other**_____

Please Specify