NAME _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____
(# & STREET) (CITY) (STATE) (ZIP)

OCCUPATION _____ EMPLOYED BY _____

WORK ADDRESS _____
(# & STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ CELL _____ BUSINESS PHONE _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____ SEX: M / F

MARITAL STATUS: S / M / D / W NAME OF SPOUSE/GUARDIAN _____

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU _____

_____
(RELATIONSHIP) (PHONE #) (ADDRESS)

WHO REFERRED YOU TO OUR OFFICE _____

YOUR FAMILY PHYSICIAN OR INTERNIST IS DR. _____
(FIRST NAME) (LAST NAME)

FAMILY MEMBERS ALSO PATIENTS HERE _____

E-MAIL ADDRESS: _____

TYPE OF INSURANCE _____

ASSIGNMENT AND RELEASE: I, the undersigned, have been advised by Dr. Burns or his staff that my eyes may be dilated for each exam. I further understand that I have been advised to provide myself with transportation and it is not recommended that I drive after being dilated. I accept all responsibility for the consequences of not following these recommended guidelines. Further, I authorize my insurance benefits to be paid directly to the physician. I am financially responsible for non-covered services.
I authorize the release of information to process insurance.

I AM AWARE MEDICARE, SUPPLEMENTAL INSURANCES, AND SOME PRIVATE INSURANCES DO NOT PAY FOR A REFRACTION. REFRACTION CHARGE IS $30.00. (Refraction is a test to determine your prescription for glasses.)

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____