

Welcome to our office. Please complete and return to the front office. Feel free to ask us if you have any questions.

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ Sex: Male/Female Marital Status: M S W D Sep.  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
Social Security (last 4 digits) XXX XX \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_  Yes, please send me reminders/promotions via e-mail  
Responsible Party \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Phone \_\_\_\_\_

If you are a new patient:

Date of Last Eye Examination \_\_\_\_\_ Place/Dr. \_\_\_\_\_  
How did you hear of us? Friend/Relative White Pages Yellow Pages Newspaper Radio Website Professional Referral Other  
Whom May We Thank? \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Medical Insurance Carrier \_\_\_\_\_  
ID # \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
Supplemental/Secondary Medical Insurance Company \_\_\_\_\_  
ID# \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
Vision Insurance Company \_\_\_\_\_  
ID # \_\_\_\_\_ Policy/Group # \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

☆ I acknowledge that I have read/received a copy of Dr Mark Noss' Notice of Privacy Practices dated April 14 2003

☆ I authorize Dr. Mark Noss to release and/or discuss information relevant to my care with other health care professionals I may be referred from/to and/or to the following individuals:

\_\_\_\_ Spouse (name ) \_\_\_\_\_  
\_\_\_\_ Other (name) \_\_\_\_\_

☆ I authorize information about my health care, including appointments or other messages to be left on my answering machine in the event I am not available.

☆ I authorize release of medical information about me to the Health Care Financial Administration (Medicare) and/or my insurance carrier for the purpose of evaluating and administering benefits.

☆ I understand that if my medical history and/or Dr. Noss' findings indicate a medical diagnosis the charges MUST be forwarded to my medical carrier, NOT my vision carrier.

☆ I understand that my insurance policy is a contract between myself and my insurance carrier and therefore I am responsible for any amount not covered by Medicare/my insurance contract.

**\*\*18% finance charge applied to balances over 30 days\*\***

This release will be considered valid from date indicated below and will remain in effect until such a time as I withdraw it in writing.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if Patient is a Minor)

Updated:  
Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_