Laser Clear Vision
Ennen
eye center

In order for us to better serve you, we ask that you complete the following information form.
Your cooperation and comments are welcomed.

Marital Status: Single/Divorced, Married, Other
(Please Circle One) Mr., Mrs., Ms., Dr., Sr., Miss

NAME _____

ADDRESS _____
STREET CITY STATE ZIP

TELEPHONE _____ E-MAIL ADDRESS _____

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____

SPOUSE OR PARENT'S NAME _____ SOCIAL SECURITY # _____

STATEMENTS ARE TO BE MAILED TO: _____
LAST FIRST INITIAL

ADDRESS _____
STREET CITY STATE ZIP

NAME OF REFERRING PHYSICIAN OR OPTOMETRIST _____

IF REFERRED IN ANOTHER FASHION, PLEASE LIST SOURCE _____

EMPLOYMENT INFORMATION

PATIENT'S OR RESPONSIBLE
PARTY'S EMPLOYER _____ TELEPHONE _____

OCCUPATION: _____

SPOUSE'S EMPLOYER _____ TELEPHONE _____

FOR USE IN CASE OF EMERGENCY

NAME OF NEIGHBOR, FRIEND OR RELATIVE
(NOT LIVING WITH THE PATIENT _____ TELEPHONE _____

INSURANCE INFORMATION

MEDICARE NUMBER _____ INSURED'S DATE OF BIRTH _____/_____/ _____

OTHER INSURANCE CO. _____ INSURED'S SSN _____

ID/POLICY # _____ INSURED NAME & RELATIONSHIP _____

GROUP # _____

INSURANCE AUTHORIZATION AND CONSENT FOR EXAMINATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE ENNEN EYE CENTER TO GIVE MY INSURANCE COMPANY OR COMPANIES, MY ATTORNEY, OR MY PHYSICIAN, ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I HEREBY ASSIGN TO THE CLINIC ALL PAYMENTS FOR MEDICAL SERVICES, SHOULD IT DESIRE TO TAKE SUCH ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I FURTHER AUTHORIZE THE DOCTORS AND STAFF OF THE ENNEN EYE CENTER TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

_____ _____
(SIGNED) DATE

_____
(RESPONSIBLE PARTY OR PARENT IF PATIENT IS MINOR)