Manzo Eye Care

Patient Information

Last Name: ___________________________ **First Name:** _________________________**Init:** ______

Address: ____ **Apt:** ___________

City: ____ **State:** ________ **Zip Code:** __________

Home Phone:___________________________ **Cell Phone:**______________________________

Work/Alternate Phone:______________________________ **E-mail:** __________________________

Gender: Male_____ Female_____ **Birth Date:** _____/_____/_____ **Age:** _____________

Social Security Number: ______________________________

Marital Status: **Single**_____ **Married** _____ **Widowed** _____ **Divorced** _____

Occupation:____

May we contact you at work: Yes_____ **No**_____ **Work Phone:** ________________________

Emergency Contact: _______________________________ **Phone:** ___________________________

Medical Doctor: ___________________________________ **Phone:** ____________________________

Address: ______________________________ **City:** ____________________ **Zip Code:** __________

Insurance Information:

Policy Holder: _____________________________ **Relationship to Patient:** ____________________

Birth Date of Policy Holder: _____/_____/_____

Policy Holder's Place of Employment: ____

Referred By: _________________________________

Reason For Visit:

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I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of insurance benefits to Manzo Eye Care. I understand that I am responsible for charges not covered by insurance.

SIGNATURE ____ **DATE** _________________

(Parent or Guardian if patient is a minor)