PATIENT INFORMATION FORM

First Name________________________________ M.I.___ Last Name______________________________ DOB___/___/___
Address___________________________________ Sex: ☐ F ☐ M Title: ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ None ☐ Other______
City/State/Zip______________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
SS # _______-_______-_______ Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Hispanic ☐ White
☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander

May we leave a message?

Home # _______-_______-_______ ☐ Yes ☐ No **Place of Employment______________________________**
Work # _______-_______-_______ ☐ Yes ☐ No **Occupation_____________________________________**
Cell # _______-_______-_______ ☐ Yes ☐ No ☐ **Retired Month/Year:_______/_______**
Texting OK? ☐ Yes ☐ No
E-mail ________________________ ☐ Yes ☐ No

PERSON RESPONSIBLE FOR BILLING

☐ **Same as above If different, please complete below.**
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other___________________________
First Name________________________________ M.I.___ Last Name______________________________ DOB___/___/___
Address___________________________________ Sex: ☐ F ☐ M Title: ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ None ☐ Other______
City/State/Zip______________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
SS # _______-_______-_______ Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Hispanic ☐ White
☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander

May we leave a message?

Home # _______-_______-_______ ☐ Yes ☐ No **Place of Employment______________________________**
Work # _______-_______-_______ ☐ Yes ☐ No **Occupation_____________________________________**
Cell # _______-_______-_______ ☐ Yes ☐ No ☐ **Retired Month/Year:_______/_______**
E-mail ________________________ ☐ Yes ☐ No

MEDICAL AND VISION INSURANCE

Medical Insurance

Primary Insurance_____________________________ ID/Policy #____________________ Group #____________________
Name of Insured First_______________________ M.I.___ Last ____________________________ DOB____/____/_____
Address of Insured_______________________________ City______________________ State_____ Zip_______________
Ph # of Insured______-_____-______ SS #______-______-______ Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Secondary Insurance___________________________ ID/Policy #____________________ Group #____________________
Name of Insured First_______________________ M.I.___ Last ____________________________ DOB____/____/_____
Address of Insured_______________________________ City______________________ State_____ Zip_______________
Ph # of Insured______-______-______ SS #______-_____-______ Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Vision Insurance

Vision Insurance______________________________ ID/Policy #____________________ Group #____________________
Name of Insured First_______________________ M.I.___ Last ____________________________ DOB____/____/_____
Address of Insured_______________________________ City______________________ State_____ Zip_______________
Ph # of Insured______-_____-______ SS #______-______-______ Relationship to Insured ☐ Self ☐ Spouse ☐ Child

(Please turn over to complete the back side)

EMERGENCY CONTACT

Name____ Relationship_________________ Phone # _____-_____-_____

In some cases, you may need or wish for another person to have access to your medical information. The following is a list of people I authorize to receive information regarding all aspects of my care with Christopher J. Nowik, OD, PC:

Name____ Relationship_________________ Phone # _____-_____-_____
Name____ Relationship_________________ Phone # _____-_____-_____

<u>ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT IN ORDER TO RECEIVE TREATMENT</u>

If patient is under the age of 18, name of parent/guardian accompanying patient to today's visit:
Name____ Relationship_________________ Phone # _____-_____-_____

I am aware that it is my responsibility to notify the office of Christopher J. Nowik, OD, PC of any changes to the information on this Patient Information form.

Signature of Patient/Parent or Guardian____Date___________________