Marc H. Sherman, O.D., F.C.O.V.D.
Steven J. Zorn, O.D., F.A.A.O

Mr. Mrs. Ms. Miss Dr.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Gender: □ Male □ Female Primary Language: □ English □ Spanish

Race/Ethnicity: □ American Indian or Alaska Native □ Asian
□ Black or African American □ Hispanic or Latino
□ Native Hawaiian or other Pacific Islander □ White

Address: _____

City: _____ State: _____ Zip: _____

Phone
Home: _____ Daytime_____ Cell: _____

Communication Preference: Email Postal Telephone: Texting □ Yes □ No

Email Address: _____

*Responsible party **if patient is a minor***

Name: _____Relationship_____Phone:_____

Occupation:_____Employer:_____

Work Status: □Full Time □Part Time □Retired □ Student □ Not Working

Driver's License #: _____State: _____

Referred By: Physician Friend Family Insurance Company Other_____

Name: _____ Phone: _____

Primary Care Physician: _____Phone:_____

Preferred Pharmacy Name and Location: _____

Primary Medical Insurance: _____

Policy Holder's Name: _____

SS# _____-_____-_____ Date of Birth: _____/_____/_____

Relationship to Policy Holder: _____

Insured ID # _____Group #: _____

Secondary Medical Insurance: _____

Policy Holder's Name: _____

SS# _____-_____-_____ Date of Birth: _____/_____/_____

Relationship to Policy Holder: _____

Insured ID # _____Group #: _____

Vision Insurance: _____

Policy Holder's Name: _____

SS# _____-_____-_____ Date of Birth: _____/_____/_____

Relationship to Policy Holder: _____

Insured ID # _____Group #: _____

Information Release:

Please list the individuals with whom we may discuss details of your medical care. Please give full name and relationship, and list any information you do not want shared:_____

_____

_____

Signature: _____ Date: _____

I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS. SHOULD MY INSURANCE DENY PAYMENT, I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OF THE SERVICES RENDERED TO ME OR ANY MEMBER OF MY FAMILY. I HAVE BEEN NOTIFIED THAT SOME SERVICES MAY BE CONSIDERED NOT MEDICALLY NECESSARY OR NON-COVERED. I ACKNOWLEDGE AND ACCEPT LIABILITY FOR PAYMENT OF THESE SERVICES.

Signature: _____ Date: _____