PATIENT DEMOGRAPHIC FORM

Date:____________ Pharmacy #: (   )_________________ SS#_____-_____-_____

Name:____

First MI Last

DOB:_________________ Sex: M / F Marital Status: M D S W

Home/Billing Address:____

Street City State Zip Code

Phone #: (   )___________ Work #: (   )___________ Cell #: (   )___________

Occupation:__________________________ If retired month/year:_______________

Employer:________________ Employer Address:______________________________

Emergency Contact:___________________________ Relationship:______________

Phone #: (   )___________ Work #: (   )___________ Cell #: (   )___________

Primary Insurance

Name:______________________ Policy #:______________ Group #:____________

Subscriber's Name:_______________________ Relationship:________________

Subscriber's DOB:____________ Subscriber Employer:_______________________

Secondary Insurance

Name:______________________ Policy #:______________ Group #:____________

Subscriber's Name:_______________________ Relationship:________________

Subscriber's DOB:____________ Subscriber Employer:_______________________

Primary Care Doctor:__________________ Address:___________________________

Phone #: (   )______________________ ___________________________

Referring Doctor (If different from primary)_________________________________

Phone #: (   )____________________ Address:______________________________

I, THE UNDERSIGNED CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND TRUE. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO OBTAIN REIMBURSEMENT FORM THE INSURANCE CARRIER (S) LISTED. FOR THOSE INSURERS WHICH PAUL D. HALPERN, O.D. ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES AS DIRECTED BY MY INSURANCE COMPANY.

Signed:___________________________________ Date:_________________