WELCOME TO DR. SHERMAN'S OFFICE!

Please help us provide the highest level of service by completing the information below. Thank you for choosing our office for all your eye care needs!

Please print legibly:

GENERAL INFORMATION

DATE_____

NAME_____ BIRTHDATE_____ SEX M F

ADDRESS_____ CITY_____ STATE_____

ZIP_____ HOME PHONE_____ WORK PHONE_____

SS#_____ OCCUPATION_____EMPLOYER_____

DRIVER'S LICENSE #_____ EXP._____

Whom should we contact in case of emergency? _____Phone_____

Is there someone special we may thank for referring you to our office? _____

Other referral source (circle): Phone Book Insurance Advertisement

VISION AND HEALTH INSURANCE INFORMATION

Do you have insurance that covers eye care? Y N
Vision Insurance Name _____ ID# _____
Medicare? Y N Medicare #_____
Other health insurance? Y N Insurance Carrier _____
Primary medical physician _____

Who is responsible for paying for your eye care expenses that are not covered by insurance?
Self Other If other: Name _____ Relationship _____
If different from above:
Address _____ City _____ State _____
Phone _____

Permission for release of all medical and insurance information is granted. I authorized payment of medical benefits to the physician for services rendered. I also understand that I am ultimately responsible for any balance due on my account.

_____ _____
Patient (or guardian) Signature Date