PATIENT INFORMATION FORM

Welcome to Dr. Leland Barry's Office

Patient Information:

Date: _____

Name: _____ **(Check one):** ☐ **Male** ☐ **Female**

Street: _____ **City:** _____ **State:** _____

Zip: _____ **Home Phone #:** _____ **Cell Phone #:** _____

Date of Birth: _____ **Social Security #:** _____/ _____/_____ **Occupation:** _____

Email: _____ **How did you hear about us?** _____

Date of last eye examination: _____ **Doctor:** _____

Date of last physical exam: _____**Primary Care Doctor:** _____

Primary Pharmacy & Address: _____

Insurance Information:

Vision **Insurance Carrier:** _____ **Medical Insurance Carrier:** _____

Insured's Employer: _____

Insurance ID #: _____

Group ID #: _____

If patient is NOT the primary member:

Primary Member's Name: _____ **Primary Member's Phone #:** _____

Primary Member's Address: _____

Relationship to Patient: _____ **Primary's Date of Birth:** _____ **Male** ☐ **Female** ☐

What is the main reason for today's visit?

_____

_____

Are you interested in any of the following: (please check all that apply)

☐ **Disposable Contacts (daily, 2 week, monthly)**

☐ **Prescription Glasses (distance or near)**

☐ **Prescription (computer)**

☐ **Progressive Lenses**

☐ **Prescription sunglasses**

PATIENT AUTHORIZATION FORM

Physician: Dr. Leland Barry, O.D.

Patient Name: _____

- ☐ I hereby assign, transfer and set over to the above-named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carriers and/or others who are financially liable for the cost of care and treatment rendered to the patient.

- ☐ I authorize the above-named physician group and facility to release any and all records, medical history, services rendered or treatment given to the patient for purposes of review, investigation or evaluation of any claim submitted to my insurer(s).

- ☐ I authorize the transferring of any and all necessary personal, medical or demographic information by the pharmacy in order to fill or refill medical prescriptions. I understand that this information may be transferred electronically, verbally or in writing.

_____ _____

Date **Signature of Patient**

_____

Printed Name of Patient