**PATIENT INFORMATION**
**DR. ALEC PERLSON OD**
**OPTOMETRIST**

Patient's Name(last,first,middle,initial):_____

Address:_____

E-Mail Address:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Social Security#:_____ Date Of Birth:_____

Refereed by:_____ Material Status:_____

Employer:_____ Occupation:_____

Spouse Name:_____ Work Phone:_____

Spouse's Employer:_____ Occupation:_____

Name Of Primary Ins CO:_____ID#:_____

Name Of Eye Care Plan:_____ID#_____

Responsible Party If Other Than Patient:_____

Address:_____Phone:_____Work#_____
Relationship of patient to person named on insurance card: Self___Spouse___Child___Other__

**Agreement: I authorize the doctor to release any information needed to process my insurance claim and**
**authorize payment directly to the physician by my insurance companies when requested by either myself or my physician. I also understand that I am fully responsible for payment of all charges whether or not they are fully reimbursed by my insurance companies.**

_____ Today's Date_____
**Signature(Patient or Authorized Party)**