BRUSH OPTICAL
PATIENT INFORMATION

Today's Date:_____ ***Info not shared with others**

Patient Legal Name_____

Preferred Prefix: Dr. / Mr. / Mrs. /Ms./Miss

Nickname (if any) _____

Address_____

City_____

State_____ Zip_____

Home Phone #_____

Daytime / Work #_____

Cell Phone #_____

Email Address*_____

Parent / Guardian_____

Name(s) of Dependent Children_____

_____

Male / Female

Date of Birth_____/_____/_____

Social Security #_____

Marital Status: Single/Married/Widowed/Divorced

Employment Status: Full Time / Part Time

Employer / School_____

Occupation / Grade_____

Communication Preference (Please circle)

Email Mail Phone

Spouse's Name_____

Spouse's Employer_____

How did you hear about our office? Billboard / Drive by / Newspaper Ad (Which paper)_____

Yellow Pages / Practice Website / Friend or Family (Name)_____

Account Responsible - If Patient is a Minor or Dependent

Name of person responsible for account _____ Relationship to Patient_____

Last First MI

Address_____ City_____State_____ZIP_____

Home Phone_____ Business Phone_____ Cell Phone_____

Employer's Name_____Phone_____

Employer's Address_____

IF THE PATIENT IS A MINOR or DEPENDENT: I hereby authorize Dr. Brush to perform diagnostic testing on

_____ Date:_____

Signature of parent or guardian_____

Insurance / Managed Care Information

To enable correct billing, you must provide **any** and **all** health and/or vision coverage at time of service.

(Please be sure the front desk has a copy of all current insurance cards)

MEDICAL

Insurance Company_____ID#_____Group #_____

Name of Insured_____ Relationship to Patient_____

Social Security #_____ Birthdate_____

Employer's Name_____ Phone #_____

Employer's Address_____

VISION

Insurance Company_____ID#_____Group #_____

Name of Insured_____ Relationship to Patient_____

Social Security #_____ Birthdate_____

Employer's Name_____ Phone #_____

Employer's Address_____

I, the undersigned, certify that I (or my dependent) have insurance with the company listed above and assign all insurance benefits directly to Gary T. Brush, O.D. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

SIGNED:_____ **DATE:**_____