

**WELCOME TO OUR OFFICE**  
**PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW.**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Preferred Title:      MR.      MRS.      MS.      MISS.      DR.      Other: \_\_\_\_\_

Birthday: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Patient or Parents Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

EMAIL Address: \_\_\_\_\_

Can we use your e-mail address to communicate with you? \_\_\_\_\_

Primary Insurance Co.: \_\_\_\_\_ Insured: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ Insured: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**RELEASE OF HEALTH/BILLING CONSENT**

I give my permission for the following person to speak with Dr. Paddock, O.D. and associates regarding my **Health Information**:

1) \_\_\_\_\_ Relationship: \_\_\_\_\_

2) \_\_\_\_\_ Relationship: \_\_\_\_\_

I give my permission for the following person to speak with Dr. Paddock, O.D. and associates regarding my **Billing Information**:

1) \_\_\_\_\_ Relationship: \_\_\_\_\_

2) \_\_\_\_\_ Relationship: \_\_\_\_\_

**PLEASE READ THE FOLLOWING**

I authorize insurance payment of medical benefits to Dr. Paddock, O.D. for all services. I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical or other information to other health care providers when requested. I also request payment of government benefits to Dr. Paddock, O.D. on my behalf. **Patients will be responsible for all charges not covered by their insurance company.**

\_\_\_\_\_  
Patient or Reponsible Party Signature

\_\_\_\_\_  
Date