PATIENT INFORMATION

Patient's Name ____ Sex M F

Date of Birth ___________________________ Social Security # ______________________

Driver's License # ______________________________ State ________________________

Mailing Address ____

City ____ State __________ Zip ____________

Home Ph # (______)____________________ Work Ph # (______) ____________________

Occupation _______________________________ Employer _________________________

Marital Status S M Name of Spouse ___________________________________

Spouse's Social Security # ____

Who is responsible for this account outside of ins. co. ? ___________________________

Name of Vision Ins. ____

Name of Medical Ins. ____

REFERRED BY:

_________ Friend or Co-Worker: __________________________________

_________ Another Doctor: ____

_________ Other family member is already a patient.

_________ Location of Office

_________ Insurance Plan

_________ Phone Book

__________ Internet

I authorize Dr. Joseph S. Powell to bill my insurance company and accept payment on my behalf.

Signature ____ Date _________________