WELCOME TO OUR OFFICE

For faster service, please complete the following form prior to arriving at our office.

Appointment Date ____/____/_____

Patient's Name (please print) _____

If a child, name of parent(s) _____

Patient's Birth Date ____/____/_____ Patient's Gender ___ Male ___ Female

Street Address _____

City _____ State _____ Zip Code _____

Preferred Phone (Home / Cell / Work) *circle one*

Home ph# _____ Cell ph# _____ Work ph# _____

e-Mail Address _____

Vision Plan _____ Member ID _____

Health Insurance _____ Member ID _____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date ____/____/_____
(Parent or guardian if patient is a minor)

BERLIN EYECARE ASSOCIATES - DR. JOSEPH POTOSKY
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