Steven J. Covici, M.D.

PATIENT INFORMATION

NAME: Mr. Mrs. Ms._____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____PHONE:HM_____

MARITAL STATUS: _____ E-MAIL ADDRESS:_____ CELL:_____

DATE OF BIRTH:_____AGE:_____SEX: M____ F_____ SS#:_____

REFERRING PHSYICIAN:_____

REFERRING PHYSICIAN ADDRESS:_____PHONE:_____

PRIMARY PHYSICIAN:_____PHONE_____

PRIMARY EYE DOCTOR:_____PHONE_____

RESPONSIBLE PARTY NAME:_____

ADDRESS:_____

EMPLOYER:_____

INSURANCE CO:_____ID#:_____GROUP#:_____

SUBSCRIBER NAME:_____DATE OF BIRTH:_____

SEX: M_____ F_____ SS#:_____COPAY:_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____

HOME PHONE:_____WORK PHONE:_____

AUTHORIZATION FOR TREATMENT AND PAYMENT

I hereby authorize Dr. Steven J. Covici and his associates to provide any treatment in the course of my examination. I also authorize the release of information and assign insurance benefit payments.

Patient Signature: _____ Date:_____

(Parent or guardian if minor)