STEPHEN A. GODLEWSKI, M.D., P.C.
VISION INSTITUTE
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PATIENT INFORMATION SHEET

LAST NAME	FIRST NAME	DATE OF BIRTH

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

EMAIL ADDRESS

SOCIAL SECURITY NUMBER	MARITAL STATUS	OCCUPATION	EMPLOYER

The following questions are a requirement of the 2009 HITECH and ARRA provision for Medicare Providers:

RACE:________________________________ETHNICITY: HISPANIC OR NON-HISPANIC (CIRCLE ONE)

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER:________________

PHARMACY NAME AND ADDRESS OR LOCATION	PHONE NUMBER

INSURANCE: I authorize Dr. Godlewski to release any information throughout the course of my examination or treatment to my insurance company and permit payment be made directly to him, at his election, any benefits due for his services, not to exceed the contracted agreement with my insurance company. I recognize and accept responsibility for any balance for fees not covered under my policy.

SIGNATURE	DATE