Circle One
Ms.
Miss
Mrs.
Mr.
Dr.

PATIENT SIGN-IN SHEET

PATIENT'S NAME _____
FIRST MIDDLE LAST

ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **PHONE ( )** _____ **( )** _____
HOME CELL

AGE _____ **BIRTH DATE** _____ **SOCIAL SECURITY NO.** _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____ **RETIRED FROM** _____

SPOUSE'S EMPLOYER _____ **SPOUSE RETIRED FROM** _____

IF MINOR, RESPONSIBLE PARTY _____

REFERRED BY _____ **FAMILY PHYSICIAN** _____

DO YOU HAVE VISION INSURANCE THAT COVERS ROUTINE EYE EXAMS?

☐ **YES** ☐ **NO** **IF YES, WHICH ONE?** _____

PERSON TO CONTACT IN EMERGENCY (NOT RESIDING AT PATIENT'S ADDRESS)

NAME _____

ADDRESS _____ **PHONE ( )** _____

I authorize the release of any medical information necessary to process claims. I hereby authorize payment directly to **Peter McCann, M.D.**, **David Wadowski, M.D.** and/or **Eye Care Associates, P.C.** for surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance. I authorize Eye Care Associates to give me reasonable and proper medical care by today's standards.

_____
Patient, Parent or Guardian Signature **Date**

FOR OFFICE USE ONLY: