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STUART A. TERRY, M.D.
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PAUL L. PROFFER, M.D.

SAMUEL HOUTKIN, O.D.
PHILIP L. SMITH, O.D.
GARY A. BORAWSKI, O.D.

Patient Information Form

(Please Print)

Patient's Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Nombre: _____ Fecha De Nacimiento: _____ Edad: _____ Sexo: _____

Check One: [ ] Child [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow
[ ] Nino/a [ ] Soltero(a) [ ] Casado(a) [ ] Separado [ ] Divorciado [ ] Biudo(a)

Number & Street/Domicilio or Direccion City/Cuidad State/Estado Zip Code/Codigo Postal Phone/Telefono
Address: _____

Social Security Number/Seguro Social: _____ Driver's License Number/Licensia de Conducir:_____

Patient's Employer/Empleo: _____ Occupation/Ocupacion: _____ Phone/Telefono: _____
Spouse's Name/Nombre De Esposo(a): _____ Phone/Telefono: _____
Spouse's or Parent's Employer/Empeo De Esposo(a)/ Padre/Madre: _____
Family Physician/Su Doctor Familiar: _____ City/Cuidad: _____ Phone/Telefono: _____

Name/Nombre City/Cuidad Phone/Telefono
In case of emergency contact:/En caso de emergencia: _____

Patient was referred by: [ ] Doctor: Name/Nombre _____ Phone/Telefono: _____
Quien lo/la referio aqui? [ ] Specialty/Especialidad: _____
[ ] Other/Otro: _____

Primary Insurance Coverage: _____ Policyholder: _____
(Aseguranza Principal) (Nombre del asegurado)
Policyholder Date of Birth: _____ Place of Employment: _____
(Fecha de nacimiento del segurado) (Lugar de empleo)
Relationship to patient: _____
(Relacion hacia el paciente)

Secondary Insurance(if applicable): _____ Policyholder: _____
(Aseguranza secundaria) (Nombre del asegurado)
Policyholder Date of Birth: _____ Place of Employment: _____
(Fecha de nacimiento del segurado) (Lugar de empleo)
Relationship to patient: _____
(Relacion hacia el paciente)

I request Braverman-Terry Eye Associates and Staff to perform those tasks necessary for medical care. All charges will be submitted to my insurance and I am responsible for that part not covered.

Les doy permiso a Braverman-Terry Eye Associates para que me den atencion medica. Ud (el paciente) va ser responsible para los cargos que su seguranza no cubre.

Date/Fecha: _____ Patient's Signature/Firma del paciente: _____

The patient was informed at the time their appointment was schedule that the examination would take approximately two hours, that their eyes would be dilated, and that they would need to arrange for a driver to return home.

El paciente fue informado que la cita puede durar aproximadamente 2 horas, y sus ojos van a ser dilatodas y va necesesitar un chofer.

Patient's Confirmation Initials/Initales del Paciente: _____ Receptionist's Initials/Initales de la recepionista: _____

Language spoken/Idioma: _____