# MANHIRE OPTICIANS

**171 Mountain Avenue**
**Hackettstown, NJ 07840**

**Welcome! Filling out this form *AS COMPLETELY AS POSSIBLE* helps provide you with the best eye care possible. Thank you!**

| First Name | Last Name | M Initial | Date of Birth | Age |
|---|---|---|---|---|
| | | | | |

**Married__ Widowed__**
**Single__ Other__**

| Social Security Number | Occupation (If student, grade in school) | Employer |
|---|---|---|
| | | |

| Gender: | Language: | Race: |
|---|---|---|
| Male____ Female____ | English____ Spanish____ Other____ | Caucasian____ African American____ Asian____ Hispanic/Latino____ American Indian____ Other____ |

| Email Address: | Contact Preference: (Check all) |
|---|---|
| | Mail____ Email ____ Home____ Work____ Cell____ |

| Home Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Work Phone/Extension | Cell Phone |
|---|---|---|
| (____) | (____) | (____) |

**INSURANCE INFORMATION:** (for help with reimbursement)

**Name of Insurer for *Vision* Care:** _____

**Name of Insurer for *Medical* Care:** _____

Name of Primary Holder: _____

Primary's Employer: _____ Primary's Employer's Address_____

Primary's Date of Birth: _____ Primary's Social Security #: _____

**PHYSICIAN & PHARMACY INFORMATION:**

| Primary Care Physician | Office Location | Phone Number |
|---|---|---|
| | | |

| Other Physician Name & Specialty | Office Location | Phone Number |
|---|---|---|
| | | |

| Pharmacy Name | Pharmacy Location | Phone Number |
|---|---|---|
| | | |

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**If Patient is a minor:**

Mother's Full Name: _____ Father's Full Name: _____

**HOW DID YOU FIND OUT ABOUT OUR OFFICE?** (Please Circle One)

**Advertising:** **Internet** **Media** **Direct Mail**

**Person:** **Family** **Friend** **Doctor** **Other**

**Name of Person we may thank for referring you:** _____

### Authorization for Use of Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Manhire Opticians, llc to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Manhire Opticians, llc. Name and relationship pf person (s) who you wish to allow access: (e.g. your spouse, son, daughter, sibling, caretaker, friend)

| Name of Person or Entity | Relationship |
|---|---|
| | |
| | |

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to Manhire Opticians, llc use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____
Signature of the Patient or Patient Representative

I understand that I, the patient or the patient's representative am/is responsible for payment of all charges for services rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____
Signature of the Patient or Patient Representative