Manhire Opticians, llc

171 Mountain Avenue
Hackettstown, NJ 07840

Patient Information (PLEASE COMPLETE ALL SECTIONS)

Last Name ____ First Name ____ M Initial ____ Date of Birth ____ Age ____

Married___Widowed__
Single____Other___

Social Security Number ____ Occupation ____ Employer ____

Language: English_____ Spanish____ Other_________	Contact Preference (Check all) Mail___ Phone___ Cell ___	Email___ ____ Email Address

Gender:
Male_____Female_____

Race: Caucasian_____
African American _____
Hispanic/Latino______
Amer. Indian ________
Asian_____
Other
____

Home Address ____ City ____ ZIP ____ ST ____

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

Patient's Employer Address ____ City ____ Zip ____ ST ____

Spouse's Full Name ____ Spouse's DOB ____ Spouse Age ____ Spouse Cell # ____

Spouse's Employer ____ Spouse's Employer Address ____ City ____ ST/Zip ____ Work Phone ____

Do You Have an Advanced Directive ? Yes_____ No_____

Referred by:
Dr. ____________________
Friend________________________
Advertising: Internet_________
Newspaper ____
Media ____
Direct Mail__
Other:
____

If Patient is a minor:

Mother's Full Name:		Home Phone :
Mothers Employer:		
Father's Full Name:		
Father's Employer:		

Pharmacy Information

Preferred Pharmacy	Street	City/ST	Phone

Physician Information

Primary Care Physician	Street Address	City/ST	Phone
Other Physicians Name and Specialty	Street Address	City/ST	Phone

Insurance Information (Please give insurance cards to receptionist to copy)

Primary Insurance:	Owners Name:
Secondary insurance:	Owners Name
Third Insurance:	Owners Name

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 have been provided a copy of the Manhire Opticians, llc Financial Policy to read. 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

I authorize the release of any medical information necessary to process all claims and authorize the release of payment for medical benefits to Manhire Opticians, llc.

____Signature of the Patient or Patient Representative