

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 Employer
(If student, grade in school)

Gender: Male__ Female__	Language: English__ Spanish__ Other__	Race: 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

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Home Phone Work Phone/Extension Cell Phone

PHYSICIAN & PHARMACY INFORMATION:

Primary Care Physician Office Location Phone Number

Other Physician Name & Specialty Office Location Phone Number

Pharmacy Name Pharmacy Location Phone Number

If Patient is a minor:

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

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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 of person (s) who you wish to allow access: (e.g. your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity	Relationship

Patient Payment Agreement

Please read & sign

I understand that Manhire Opticians is an **insurance-free, self-pay only** office. 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