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__ ________________ ________________

Last 4 Social Security # **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

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: ______ ______________

MANHIRE OPTICIANS

171 Mountain Avenue
Hackettstown, NJ 07840

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

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