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** **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**

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

Name of Person or Entity & Phone Number	Relationship

Patient Payment Agreement

Please read & sign

I understand that Manhire Opticians **does not accept any insurance**. I understand that Manhire Opticians is a **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

_____

Today's Date