Eyecare Medical Group
53 Sewall Street
Portland, ME 04102
(207) 828-2020

PATIENT INFORMATION

_Mr. _Mrs. _Ms.
_Rev. _Sr. _Dr.

Patient: _____ Date of birth: _____ Age: _____ Sex_____

(please use full legal name)

Address: _____ City: _____ State: ____ Zip:_____

Telephone (home):_____ (work): _____ (cell phone):_____

Soc Sec #: _____ E-Mail address:_____

Employer:_____

Parent/guardian (if patient is a minor), or Power of Attorney:_____

Billing name and address (if other than patient):

_____

Name and address of regular eye doctor:_____

Date of last eye exam:_____

Name and address of the doctor that referred you to EMG:_____

_____

Name and address of your primary care physician:_____

_____

In case of emergency, notify:_____ Telephone # _____

2nd Emergency contact:_____ Telephone # _____

(please list someone other than a household member)

- **Please bring a referral from your primary care doctor, if your insurance requires a referral.**
- **Please be prepared to show a photo I.D. and all insurance coverage cards upon arrival.**
- **Please bring a list of your current medications.**

Name of Your Insurance:

Primary Insurance:_____ Policy Holder:_____

Secondary Insurance:_____ Policy Holder:_____

How did you hear about EMG?

__Family Member __Friend __Physician Referral __Yellow Pages __Newspaper __TV

__Radio __Print Ad __Website/Internet Other:_____

Authorization and Release:
I authorize the release of any information including diagnosis, records of treatment or Examination, to third party payors and/or other health practitioners.

_____ _____

Signature of patient or parent, if minor, or Power of Attorney Date