THOMAS A. PLANCHARD, M.D.

(PLEASE PRINT OR WRITE LEGIBLY)

TODAY'S DATE: ________________

NEW PATIENT INFORMATION RECORD

PATIENT'S NAME	MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER

PHYSICAL ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.
MAILING ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

NAME AND ADDRESS OF NEXT OF KIN (OTHER THAN SPOUSE)	CITY, STATE, AND ZIP CODE	HOME PHONE NO.

PERSON RESPONSIBLE FOR PAYMENT (IF NOT ABOVE)	CITY, STATE, AND ZIP CODE	HOME PHONE NO.	BUSINESS PHONE NO.

NAME OF FAMILY DOCTOR	ADDRESS	PHONE NO.
NAME OF REFERRING PHYSICIAN OR OPTOMETRIST	ADDRESS	PHONE NO.

❑ **SELF PAY** ❑ **INSURANCE**

INSURANCE INFORMATION (ENTER ALL INFORMATION AS IT APPEARS ON YOUR CARD)

PRIMARY INSURANCE

POLICY HOLDER'S NAME (AS IT APPEARS ON CARD)	POLICY NUMBER	EFFECTIVE DATE

SECONDARY INSURANCE

POLICY HOLDER'S NAME (AS IT APPEARS ON CARD)	POLICY NUMBER	EFFECTIVE DATE

THIRD INSURANCE

POLICY HOLDER'S NAME (AS IT APPEARS ON CARD)	POLICY NUMBER	EFFECTIVE DATE

METHOD OF PAYMENT (PLEASE CHECK ONE) ___ CASH ___ CHECK ___ VISA/MC/DISC/AM EXP

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETE TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE SIGN AND READ)

I HEREBY AUTHORIZE THOMAS A. PLANCHARD, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

____

YOUR HELP WITH THE FOLLOWING INFORMATION WOULD BE GREATLY APPRECIATED!!!! HOW DID YOU HEAR ABOUT OUR OFFICE?

_________ (P)HONE BOOK _________ (N)EWSPAPER ___________ (R)ADIO _____________ (T)V ___________ (D)OCTOR REFERRAL

______ REFERRAL FROM (O)PTOMETRIST ______ REFERRAL FROM (F)RIEND/RELATIVE ______ (I)NSURANCE PLAN ______ (S)EMINAR

(OVER)

Your answers to this questionnaire may be very helpful to the doctor. PLEASE PRINT and answer all questions.

1.	Have you ever had an eye injury or eye operation?	NO	YES
2.	Were your eyes "crossed" as a child?	NO	YES
3.	Do you have, or have you had high blood pressure?	NO	YES
4.	Do you have kidney trouble?	NO	YES
5.	Do you have diabetes?	NO	YES
6.	Do you have ANY chronic or serious illness? . . . . Please List:	NO	YES
7.	Are you allergic to any medicines? . . . . Please List	NO	YES
8.	List any medication you are taking or have taken in the past year. Name or purpose of each:		
9.	Do you now, or have you ever worn glasses?	NO	YES
10.	Are there any relatives in your family who are blind or nearly blind through other causes than by accident?	NO	YES
11.	Do you have any family history of glaucoma?	NO	YES
12.	Do you have any family history of cataracts?	NO	YES
13.	Do you have a "Lazy" eye?	NO	YES