QUINLAN
EYE SURGERY
& LASER CENTER

Patient Information

Last Name: First Name: Middle Initial: Nickname/AKA:

Date of Birth: ___/___/____ Social Security Number: ____-____-____ Gender: □ M □ F
Home Address: _____ Apt #:_____
City: _____ State: _____ Zip Code: _____
Employment Status: □ Student □ Disabled □ Retired □ Self Employed □ Other
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Life Partner □ Other
Race: □ American Indian/Alaskan Native □ Asian Black/NonHispanic □ Hispanic □White/NonHispanic □ Other
Smoking: □ Y □ N Cigarettes Per Day: _____ Packs Per Day: _____ Number of Years _____

Physician Referral Information

Primary Care Physician:_____ Referring Physician: _____
How did you hear about us? □ Insurance Company □ TV □ Radio □ Phone Book
□ Family Friend □ Newspaper □ Physician □Website □ Other

Responsible Party (Guarantor) Information

Relationship to Patient: □ Self (If yes skip to emergency) □ Spouse □ Parent □ Other
Last Name: First Name: Middle Initial:

Date of Birth: ___/____/____ Social Security Number: ____-____-____ Work Phone: _____

Emergency Contact Information

Last Name: First Name: Middle Initial:

Date of Birth: ___/____/____ Cell Phone: ____-_____-_____ Work Phone: ____-_____-_____

Please Provide Us With Names That We May Release Information To

Last Name: First Name: Relationship to Patient:

Last Name: First Name: Relationship to Patient:

PLEASE DO NOT RELEASE INFORMATION TO ANYONE Signature:_____

Please Initial Each Line: I have been provided the HIPPA Privacy Policy ____, The Patient Privacy Policy ____ and Insurance Payment Procedures and I agree to these Policies and Procedures. I hereby authorize Gregory H. Quinlan, D.O. to provide treatment.

Signature: _____ Date: ____/_____/_____