

Manhattan Vision Associates

Patient Intake Form

Name: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Work#: _____ Home#: _____

E-mail Address: _____

DOB: ___-___-_____ Age: _____ SS#: _____

Occupation: _____ Employer: _____

Do you have a vision benefit? YES NO If so, which one? _____

How did you hear about MVA? _____

Family Physician: _____ Phone #: _____

Are you interested in laser vision correction? YES NO

Date of last eye exam: _____

Insurance Information

Major Medical: _____

Policy Holder: _____

ID#: _____

Insurance Authorization and assignment of benefits

I hereby authorize Manhattan Vision Associates to furnish insurance carriers any information concerning my condition and treatments and I hereby assign to Manhattan Vision Associates all payment for services rendered to my dependents or myself. I understand that I am responsible for the amount not covered by my insurance.

Date: _____ Signature: _____