



MANHATTAN VISION ASSOCIATES
PATIENT INTAKE FORM

Male Female Married Single Partner Widowed Divorced

Name: _____

Address: _____ Apt. or floor: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

E-mail address: _____

Birth date (month / day / year): _____ Age: _____ Soc. Sec. number: _____

Employer: _____ Occupation: _____

Family physician: _____ Physician phone: _____

Emergency contact: _____ Emergency phone: _____

How did you hear about MVA? _____

Are you interested in Laser Vision Correction? Yes No Date of last eye exam: _____

I authorize the staff or doctors of Manhattan Vision Associates to leave voicemail messages for me, email me, or text message me regarding product status notifications (e.g. glasses ready to be picked up), appointment reminders, test results, diagnoses and treatments.

Voicemail: Yes No Email: Yes No Text message: Yes No

INSURANCE INFORMATION

Major medical: _____ Member ID number: _____

Name of policy holder: _____

Do you have a vision benefit? Yes No

If yes, which one? Davis VSP OPTUM Spectera EyeMed

Vision plan ID number: _____

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 payments for services rendered to my dependants or myself. I understand that I am responsible for the amount not covered by my insurance.

Date: _____ Signature: _____

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