WOOLFSON
EYE INSTITUTE

Patient Data Sheet

(This Information is Confidential)

Patient Name: _____
First Middle Initial Last

Preferred Name (nickname / if different than first name):_____

Mailing Address:_____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Email Address: _____

Employer: _____ Occupation: _____

Birth Date: _____ Age: _____ Sex: ❑ Male ❑ Female

Social Security No:_____ Insurance Carrier: _____

Current Optometrist or Ophthalmologist: _____

How did you hear about us: ❑ Doctor ❑ Radio ❑ Magazine ❑ Billboard ❑ Other: _____
❑ Relative/Friend – Name: _____

Person to Notify in Case of Emergency: _____

Phone: _____ Relationship: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Dr._____ (referring doctor) to disclose complete information to Woolfson Eye Institute concerning his/her medical findings and treatment of the undersigned.

Patient Signature _____ Date _____

Date _____

Parent or Guardian signature if patient is a minor _____