☐ Sid Mandelbaum MD
☐ Michael Borodkin MD

Date ____________________

PATIENT INFORMATION

Last Name ______________________ First ______________________ M.I. ____

DOB ______ / ______ / ________ Age ________ Sex M F Marital Status S M W D

Home Address ______________________ City ____________ State ____ Zip ______

Home Phone (_____) _____ - ________ Soc. Sec. # ______ - _____ - ______

Email ____

Your Employer ______________________ Occupation ______________________

Work Address ______________________ City ____________ State ____ Zip ______

Work Phone (_____) _____ - ________ Alternate Phone/Cell (_____) _____ - ________

Recommended By ______________________ If you were referred by a physician, what is their specialty? ☐ Ophthalmology ☐ Optometry ☐ Medicine ☐ Other

Address ______________________________ Phone (_____) _____ - ________

Your other physicians (Primary Care, Cardiologist, etc.)

Physician's Name	Specialty	Phone
________________	________________	(_____) _____ - ________
________________	________________	(_____) _____ - ________
________________	________________	(_____) _____ - ________

Pharmacy Name & Address ______________________ Phone (_____) _____ - ________

Person Responsible for Bill (if other than yourself) ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ____________

Last Name ______________________ First ______________________ M.I. ____

Birth Date _____ / _____ / ________ Sex M F Soc. Sec. # ______ - _____ - ______

Home Address ______________________ City ____________ State ____ Zip ______

Home Phone (_____) _____ - ________ Cell Phone (_____) _____ - ________

INSURANCE INFORMATION

Insurance #1 ____

Policy # ______________________ Group No. (or name) ______________________

Insured's Name ______________________ Relationship __________ DOB ____ / ____ /____

Do you have secondary insurance? ☐ Yes ☐ No

Insurance #2 ______________________ Policy # ______________________

AUTHORIZATION

I hereby authorize the physicians indicated above to furnish information to insurance carriers concerning my illness, accident and/or treatments. I hereby assign to the above physicians all payments for medical services rendered to myself or to my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as effective and valid as the original.

Signature ______________________________________ Date ______________