Welcome to Dr. Robert C. Crowe's Office

Name of Patient_____ Date_____

Date of Birth_____ Age_____

Date of Last Eye Exam_____ Referred By_____

List all Medications_____

Drug Allergies_____

Type of Vision Insurance_____ Social Security #_____

Home Address_____ City_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Employer_____ Occupation_____

Spouse/Parent/Guardian Name_____

Employer_____ Occupation_____

Children's Names at Home_____ Age_____

_____ _____

_____ _____

All fees are due and payable at the time of service, unless prior arrangements have been made.

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Signature_____ Date_____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient_____ Print Name_____

Source of Authority_____