



LARRY R. LAWRENCE, MD * ERIC J. POULSEN, MD * ALAN T. ISRAEL, OD
1360 E. HERNDON AVE., SUITE #201 FRESNO, CA 93720 (559) 449-5050

PATIENT INFORMATION FORM

Patient Name: First Middle Last

If patient is a minor, name of responsible party:

Home Address: Home Phone:

City: State: Zip:

Social Security Number: Married Single Divorced Widowed

Birth Date: Age: Male Female

Responsible Party Employed by: Occupation:

Business Address: Business Phone:

Name of Spouse: Spouse Employed by:

Family Physician: Address:

City: State: Zip:

In Case of Emergency Contact: Phone:

Who may we thank for referring you to this office?:

Address: City: State: Zip:

Primary Insurance Company:

ID No. Group No.: Phone No.:

Secondary Insurance Company: ID No. Group No.:

Insurance Authorization and Assignment: (Please read and sign below)

I hereby authorize Lawrence Eye Associates Medical Group, Inc. DBA InSight Vision Center to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: Signature: