

CHRIS M. PETRAS M.D.
PATIENT INFORMATION

(Please Print)

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security No.: - -			Birth date: / /		Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:					Home phone: ()		
City:		State:		ZIP Code:		Cell phone: ()	
Occupation:		Employer:				Employer phone: ()	
Referred by:		<input type="checkbox"/> Dr.	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:	
Other family treated here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name:			Relation:
Purpose of Visit:							
Current Medications:							
Medical Problems:							
Drug Allergies:							
Do Any Family Members Have Glaucoma?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do Any Family Members Have Any Other Eye Disease?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:		

BILLING INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Address (if different):		Home phone: ()	
Responsible Persons Social Security No.: - -		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship:	
Occupation:	Employer:	Employer address:			Employer phone: ()

IN CASE OF EMERGENCY					
Name of friend or relative:		Relationship to patient:	Home phone: ()	Work phone: ()	Cell phone: ()
<p>NOTE TO RESPONSIBLE PARTY: Payment is expected at the time of service for all charges. (Medicare, Medicaid and Workman's Comp claims will be filed for you). If you are unable to pay for your service today, please speak to the receptionist prior to seeing the doctor.</p> <p>INSURANCE CLAIMS: FOR SURGERY OR ACCIDENTS: Any claims filed for you are to be paid within 45 days from the date of service. You will be billed for any claims your insurance carrier fails to pay within this 45 day period.</p> <p>I HAVE READ the above and understand my financial obligation. I agree to make all necessary payments for services rendered. In addition, I understand that the patient (parent or guardian) is fully responsible for total payment of services including any amounts not covered by any health insurance or prepayment programs the responsible party may have. If the account is turned over for legal collection, the patient (parent or guardian) is also responsible for all costs of collection plus attorney fees.</p>					
Patient/Guardian signature: _____			Date: _____		