## **FAMILY VISION CARE**

PATIENT INFORMATION			
PATIENT NAME:	DATE OF BIRTH		AGE:
ADDRESS:			
HOME: CELL:			
MESSAGES: [ ] CALL [ ] TEXT [ ] EMAIL LAST FOUR SS#: REFERRED BY:			
EMAIL:			
PHARMACY:			
FAMILY DOCTOR:			
ADDRESS:	CITY:	STATE:	_ ZIP:
HIPAA RELEASE OF INFORMATION * ACK	(NOWLEDGEMENTS * MEDI	CAL INSURANCE PO	DLICY
I AUTHORIZE THE RELEASE OF INFORMATION IN:	CLUDING DIAGNOSIS, RECORDS, EXAMINATION		
THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UN			):
* HIPAA RELE	ASE OF INFORMATION *		
NAME:	RELAT	IONSHIP:	
NAME:	RELATIO	NSHIP:	
PATIENT or GUARDIAN SIGNATURE:		DATE:	JI
PATIENT or GUARDIAN SIGNATURE:		DATE:	J
	IVACY NOTICE *	DATE:	
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