



47670 Van Dyke Shelby Twp., Michigan 48317  
P 586.323.2020 F 586.323.4145 www.2020vision.com

Patient's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

No P.O. boxes

S.S. #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M or F

Marital Status: S M W D Home Phone #: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ MD/DO City: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Referred by Dr: \_\_\_\_\_ Other: \_\_\_\_\_

Emergency Contact 1: \_\_\_\_\_ Phone #: \_\_\_\_\_

PATIENT INSURANCE INFORMATION:

Medical Insur Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have vision coverage? Yes / No If yes, what company: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP code: \_\_\_\_\_

SPOUSE INSURANCE INFORMATION:

Spouse's Name: \_\_\_\_\_

Spouse's Birthdate: \_\_\_\_\_ Spouse's Soc Sec #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

WORKER'S COMP:

Date of Injury: \_\_\_\_\_ Case #: \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone #: \_\_\_\_\_

I authorize the release of any medical information necessary to process claims and authorize payment of benefits to William S. Goldstein, M.D., P.C. I understand that I am responsible for any unpaid balance on my account. My signature also authorizes examination and treatment by Dr. Goldstein and his staff for myself/ my dependant.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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We would like your permission to contact you to confirm your appointments, and to give you test results when necessary. Please tell us how we may contact you!

I wish to be contacted in the following manner (check all that apply):

| Home/Cell Phone  | Work Phone   | Email   | Written Communication                                  |
|--|--|---|--|
| <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Ok to email me with detailed information | <input type="checkbox"/> Ok to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only      | <input type="checkbox"/> Leave message with call-back number only      | <b>We will not sell or use email for any other purpose!!</b>      | <input type="checkbox"/> Ok to mail to my work address |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**OFFICE POLICY**

**EFFECTIVE 6/1/08**

Due to an increase in incidents, we will be enforcing the following office policy effective June 1, 2008:

- **CONVENIENCE CHARGE FOR NON-PAYMENT AT TIME OF SERVICE (EXAMPLE: CO-PAY)- \$15.00**
- **CREDIT CARD OVER-THE-PHONE CONVENIENCE FEE - \$10.00**
- **PATIENTS WHO FAIL TO CALL TO CANCEL AN APPOINTMENT (EXCEPT IN EMERGENCY SITUATIONS) WILL BE SUBJECT TO A NO-SHOW CHARGE - \$40.00**