Lawrence R. Goldberg, M.D.
Eye Physician and Surgeon

PATIENT INFORMATION

Please print the following information

Last Name _____ First Name_____ Middle Initial _____

S.S. Number_____ Date of Birth_____ Sex: M F Marital Status: S M W D

Home Address_____ Apt/Unit#_____

City _____ State _____ Zip _____

Home Phone#_____ Cell# _____ Work# _____

E-Mail _____

Occupation_____ Employer_____

Name of Spouse, Nearest Relative or Responsible Party_____

Emergency Contact Person _____Relationship_____ Phone #_____

If you have an "Out of Town" or Alternate address and phone please complete:

Address_____

Phone # _____ Date this address is valid: From _____ To _____

Name of primary care physician _____

If you were referred by a physician or patient please list name _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) POLICY:

I acknowledge that I have been given an opportunity to read a copy of the policy relating to the Federal Government's HIPPA privacy regulations and how it relates to patient care. I also acknowledge that I have been given the opportunity to ask questions concerning this policy.

I give permission for Lawrence R. Goldberg, M.D. to contact me concerning appointments, treatment, diagnoses, payments and other private health information: Yes____ No____

Please indicate below the names of individuals to whom we may release information contained in your medical chart.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature **Date**