



• ERIC J. POULSEN, MD • AZHAR I. SALAHUDDIN, MD • SHARON S. HIYAMA, OD  
• PATRICK J. SCOTT, OD • DAVID M. POULSEN, MD, MPH

1360 E. HERNDON AVE., SUITE #201 FRESNO, CA 93720 (559)449-5050 Fax (559)432-2632

## PATIENT INFORMATION FORM

Patient Name: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

Social Security Number: \_\_\_\_\_  Married  Single  Divorced  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

If patient is a minor, name of responsible party: \_\_\_\_\_

Responsible Party Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Parent/Guardian SSN: \_\_\_\_\_ Parent/Guardian Birth Date: \_\_\_\_\_

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: \_\_\_\_\_

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

I hereby authorize InSight Vision Center Medical Group, Inc. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physicians(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:** \_\_\_\_\_