ADELSON
EYE & LASER CENTER

Dr. Howard Adelson, D.O., FAOCO
Dr. Todd Adelson, D.O., FAOCO

PATIENT REGISTRATION / MEDICAL INFORMATION RELEASE

Last Name _____ First Name _____ Initial ___

Address _____ City/State/Zip _____

Home/Cell Phone _____ Work Phone _____ Email _____

Date of Birth _____ Social Security # _____ Male I Female

Employer _____ Occupation _____

Emergency Contact _____ Phone # _____ Relationship _____

How did you hear about our office? _____

Primary Care Physician _____ Phone # _____

Optometrist _____ Phone # _____

I hereby authorize Dr. Adelson to discuss with and/or release any information to the following person(s). If you want your spouse to have access to this medical information, the name must also be listed below. Also, children 18 years or older must give permission for their parents to have access to their medical information.

I, _____ give permission to the physicians and staff at Adelson Eye & Laser Center to discuss any medical information with the following person(s):

_____ Relationship _____

_____ Relationship _____

Do you give us permission leave a message on your voicemail in the event we cannot get a hold of you?

❑ Yes ❑ No | Phone Number _____

This permission includes discussing results of examinations, x-ray and laboratory findings, future testing to be scheduled and information pertaining to insurance billing. I also give my permission to allow the above named individual(s) to sign for and receive copies of any and all medical records.

I authorize the release of any information necessary, including my medical record, to process any insurance claim.

_____ _____
Patient Signature (or person authorized) Date