

PER HIPPA REGULATIONS, PLEASE PRINT COMPLETED FORM AND BRING TO YOUR APPOINTMENT



**Stuart R. Winthrop, M.D.**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Billing Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

Secondary Address \_\_\_\_\_  
Street City State Zip

Status:  Minor  Single  Married  Significant Other  Divorced  Widow

E-Mail \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone Number (\_\_\_\_) \_\_\_\_\_  Home  Work  Cell SS# \_\_\_\_\_

Current eye care practitioner \_\_\_\_\_

Whom do we thank for this referral? \_\_\_\_\_

What/who influenced your decision to see Dr. Winthrop? (Please check all that apply)

- Doctor  Friend/Family  Reputation  Website  Online Ad  TV Commercial  Yelp  Facebook  
 Other \_\_\_\_\_

**PLEASE COMPLETE THIS SECTION IF DIFFERENT FROM PATIENT INFORMATION**

Insurance Policy Holder and/or Responsible Party. If you are a minor, Parent or Legal Guardian

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

**PLEASE BRING YOUR CURRENT INSURANCE CARD(S) TO PRESENT TO THE FRONT DESK PERSONNEL**