Laurie Boquet Dory, M.D.
Comprehensive Eye Care

901 Travis Avenue Fort Worth, TX 76104
Ph (817) 332-5585 Fax (817) 332-5377

Thank you for choosing our practice for your eye care needs.

Please complete this form as accurately as possible. This information is necessary in order to maintain important patient and Physician contact and to properly bill your insurance company on your behalf.

PATIENT INFORMATION:

Name: _____
(First) (Middle) (Last)

Birth Date: _____ **Age**: _____ **Social Security #**_____

Sex: Male ___ Female____ **Marital Status:** Single___ Married___ Divorced___ Widowed____

Address: _____ **Apt #** _____

City: _____ **State**: _____ **Zip**:_____

Best Daytime Phone #_____

Cell or Alternate Phone #_____ **Work #**_____

Employer's Name: _____ **Occupation**:_____

Emergency Contact Person: _____

Relationship: _____ **Phone #**: _____

Name and Information for primary insurance policyholder:

Name: _____ **(Relationship to patient)** _____

Birth Date: _____ **Social Security #** _____

Address: _____ **Apt #** _____

City: _____ **State**: _____ **Zip Code**: _____

Home or Cell Phone # _____

Name of Employer: _____

Work Phone # _____

Referring Physician's Name: _____

Referring Physician's Phone # _____

(PCP) Primary Care Physician's Name: _____

PCP's Phone # _____

Local Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

I hereby assign payment directly to Laurie Boquet Dory, M.D. for medical and surgical services rendered to myself or to my dependents. I understand that I am financially responsible for any charges not covered by this assignment. I also authorize Laurie Boquet Dory, M.D. to release any information in the course of my examination or treatment for insurance purposes or medical treatment.

Signature: _____ **Date:** _____