STEPHEN L. SINOWAY, O.D.
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HUNTERDON FAMILY EYE CARE
1465 ROUTE 31 SOUTH
ANNANDALE, NJ 08801
(908) 730-6774 • FAX 730-9011

Welcome! Filling out this form *AS COMPLETELY AS POSSIBLE* helps provide you with the best eye care possible. Thank you.

Name: Mr. Mrs. Ms. Miss Dr. Rev.

First Name: __________________________ Last Name: __________________________Friends call me: _______________

Date of Birth: ____________ Age: ________ Social Security #: ________________

Marital Status: Single___; Married ___; Divorced ___; Widowed ___; Name of Spouse: ________________________

Address: ____________________________________ City: ____________________ State: ______ Zip: ____________

Home Phone: ____________________ Daytime Phone: ___________________________

Cell Phone: ______________________ ( ) ok to text E-mail Address: __________________________ ( ) ok to email

***The best number where we can reach you during business hours: ____________________________**

Occupation (if student, grade in school): ___________________________________

Employer (if student, name of school): _____________________________________

Name of Insurer for *Vision* Care: ____

Name of Insurer for *Medical* Care: ____

Name of Primary Holder: ____

Primary's Date of Birth: _______________________ Primary's Social Security #: _____________________________

PRIMARY CARE PHYSICIAN: ________________________ Office Location: _______________________________________

PHARMACY NAME: _________________________________ Pharmacy Location: ____________________________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE? ***(Please Circle One)***

Internet Yellow Pages Friend Relative Healthcare Practitioner School Co-worker Drove Past Office Other

Name of Person we may thank for referring you: ____

PAYMENT POLICY & RELEASE OF PATIENT INFORMATION

Payment is expected when services are rendered, unless other arrangements are made in advance. *It is your responsibility to know your insurance coverage for your routine/medical exams an/or materials.* Insurance that covers your visit must be presented at time of visit, or the patient will be responsible for lab fees if glasses or contacts are not ordered from your insurance lab. Glasses must be dispensed to you within 60 days of purchase or they will be dismantled and deposit will be lost. The patient or responsible party will pay for services rendered which are not fully covered by an insurance or third party plan. If an account becomes delinquent, the patient will pay the balance plus reasonable collection agency and/or attorney fees and interest on the unpaid account.

For your protection, Contact Lenses may not be reordered without a yearly exam. Polycarbonate lenses (for eyeglasses) are recommended for all our patients, since they are the safest lens available. I give my permission for this office to exchange exam or chart information with insurance or third party carriers and consulting doctors or professionals involved in my care. My consent is good for all future services.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS:

____ Date: _______________
(Signature of patient or responsible party)

Rev.01/08/16