BRIAN M. BROWN, MD
EXCELLENCE IN EYECARE

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PATIENT INTAKE FORM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ACCT #
PRIMARY TELEPHONE #	SECOND TELEPHONE #	DATE OF BIRTH	DL #
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY #	SEX (M/F) / MARITAL STATUS	EMAIL	
OCCUPATION	EMPLOYER	NATURE OF BUSINESS	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE #	FAMILY DOCTOR	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE # RELATIONSHIP	
PRIMARY INSURANCE PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER #	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE #	INSURED'S SOCIAL SECURITY #	
SECONDARY INSURANCE	INSURANCE NAME & ADDRESS		
SUBSCRIBER #	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE #	INSURED'S SOCIAL SECURITY #	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE

**** PLEASE READ AND SIGN BELOW ****

AUTHORIZATIONS TO RELEASE MEDICAL RECORDS INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I hereby authorize payment to Brian M. Brown, M.D. the insurance benefits to which I am entitled. I understand that I am financially responsible for charges not covered by my insurance. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: _____
(Parent/Guardian, if minor)

I hereby authorize Brian M. Brown, MD Inc to provide information to insurance carrier and/or referring or family physician concerning my condition and treatment rendered. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: _____
(Parent/Guardian, if minor)