John T. Dawson, M.D.
Kevin T. Gallaher, M.D.

Please complete all sections of this form to the best of your ability

Name ______________________________ **Date of Birth** ____________________

Address ______________________________ **SSN** ____________________

City ____________________ **State** ____________________ **Zip** ____________________

Home☐ ____________________ **Work**☐ ____________________ **Cell**☐ ____________________

Please check the box(es) at the numbers above permitting us to contact you for appointment reminders/correspondence.

Email Address ______________________________ **Employer** ____________________

Sex (circle one) **M / F** **Marital Status** (circle one) **S M D W**

Race ____________________ **Ethnicity** (circle once) **Hispanic/Latino Not Hispanic/Latino**

By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your healthcare needs. If you prefer not to complete the race and/or ethnicity portion of this form, please write refused in the space above.

Emergency Contact ______________________________ **Phone** ____________________

Preferred Pharmacy ______________________________ **Location** ____________________

Referring Physician ____________________ **Primary Care Physician** ____________________

Friends/Relatives we may release your medical information to:

Name ______________________________ **Relationship** ____________________

______________________________ ____________________

Insurance Information

Policy Holder Name ______________________________ **Date of Birth** ____________________

Relationship to Patient ______________________________

- I authorize the release of any medical information necessary to process this claim. I also request payment of benefits to the provider on all claims that he may accept assignment on. I understand that I am responsible for all non-covered services and any balance that may not be covered by insurance. ________ (initial)
- I authorize the release of any information in my chart to any medical practitioner, insurance company, doctor, hospital, pharmacy, optical dispensary or any other medical institution to which I may be referred to assist with my medical care. ________ (initial)
- **I understand that an annual refraction fee of $40.00 will not be covered by most health insurance policies and that I am responsible for payment of this fee plus my copay (if applicable) at the time of service. A refraction is a vision test that is a necessary part of a complete eye exam.** ________ (initial)
- I acknowledge the Notice of Privacy Practices is kept on file in the practice and is available for my review and can be explained to me if I have any questions. ________ (initial)

Sign ______________________________ **Date** ____________________