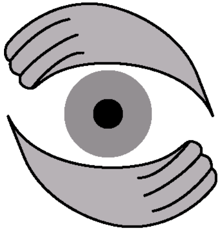

Lehigh Valley

CENTER FOR SIGHT, P.C.

1739 Fairmont St. • Allentown, PA 18104 • 610-437-4988 • Fax 610-437-4176
538 Delaware Ave. • Palmerton, PA 18071 • 610-826-222 • Fax 610-826-4001
1204 Delaware Ave. • Bethlehem, PA 18015 • 610-865-5321 • Fax 610-865-7409

William M. Trachtenberg, M.D.
Daniel I. Ross, M.D.
Mark E. Moran, D.O.

Houman Ahdieh, M.D.
Maria Panayotova, M.D.

PATIENT INFORMATION

Name____ Birthdate_______________Age_____________

Street Address____

City_________________________________ State__________ Zip____________ Male / Female

Social Security # ___________ - ________ - ___________ Home Phone Number___________________

Cell Phone Number_____________________

Employer____ Work Phone Number___________________

Occupation_______________________________________ E-mail Address_______________________

May we contact you via your E-mail address? Y / N

Spouse's Name______________________________ Marital Status: S M D W

How long ago was your last eye exam?____

Referred by:____

Family physician's name____

Address____

Is this a work related injury? Yes / No Date of injury____

If yes, we still require a copy of your medical insurance card and a referral if necessary.

"I request that payment of authorized benefits be made either to me or on my behalf to the Lehigh Valley Center for Sight, P.C. for any service furnished to me by Dr. Trachtenberg, Dr. Ross, Dr. Moran, Dr. Ahdieh, or Dr. Panayotova. I authorize any holder of medical information about me to release to the above mentioned insurance company and its agents any information needed to determine these benefits or the benefits payable for related services."

X Patient's or Guardian's Signature____ Date___________

Form of payment today: Cash Check Credit Card

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY.