Welcome to the office of Dr. Robert M. Barton, Jr.

Thank you for choosing us for you eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

First Name ____ MI ____ Last Name ____ Date of Birth ____ Social Security Number ____

Mailing Address ____ City ____ State ____ Zip ____ Occupation ____

Cell Phone ____ Home Phone ____ Work Phone ____ Email Address ____

Spouse or Parent(s) Name(s) ____ Primary Care Doctor ____ Primary Care Dr. Phone Number ____

Person Responsible for Account ____ Responsible Party SS#& Date of Birth ____ Responsible Party Employer, Address & Work Phone ____

Preferred method of contact: (circle one) TEXT EMAIL LANDLINE

IF NO CHANGES TO YOUR INFORMATION, PLEASE INITIAL HERE ____________________

Vision Insurance Information

Company: ID #: Group #:

Subscriber's Name: ____________________ Subscriber's DOB: ____________________

Subscriber's Employer: ______________ Patient Relationship to Insured ______________

Self, Spouse, Child, Other

Medical Insurance

Company ____________________ ID# ____________________

Subscriber's Name ______________________________ Subscriber's DOB: ______________

Authorization for dilation

In the process of today's examination, the doctor may recommend dilation for further examination of your eyes. Dilation may not be part of the routine examination, thus it may be an additional expense. If so, do you wish to be dilated today? _______ Yes _______ No

Authorization to Release Medical Information

I authorize Robert M. Barton, Jr. O.D. to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing. _______ Yes _______ No

Patient/Guardian Signature______________________________ Date ____________________