

**Dr. Michael J. Bermel, P.C.
Dr. Krista M. Davis Dr. Simi Bhardwaj
OPTOMETRISTS**

PATIENT INFORMATION SHEET

Patient Name: _____

Date of Birth: _____ SS# _____ - _____ - _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Home Phone: _____ Alternate Phone: _____

Patient Email Address _____

Emergency

Contact: _____ Phone: _____ Relationship: _____

Marital Status (circle one) Single Married Divorced Widowed

Due to various medical conditions which may be more prominent in different races, please state your race: _____

If patient is under 21, please provide the following:

Name of Parent or Guardian: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Relationship to Patient: _____

INSURANCE INFORMATION

VISION PLAN INFORMATION

Policy Holder Name: _____

Date of Birth: _____ Age _____

Type of Insurance _____ Policy # _____

Group# _____

Insured's Mailing Address (or write "Same As Above"):

Policyholder SS# _____ - _____ - _____

Policyholder's Employer _____

Effective Date of Coverage _____ Relationship to Patient _____

Insurance Company Claims Address _____

Leesburg ▪ 55A Catocin Circle NE ▪ 20176 ▪ (703) 777-3455
Fairfax ▪ 10640 Main Street # 100 ▪ 22030 ▪ (703) 691-2020
Ashburn ▪ 43330 Junction Plaza # 120 ▪ 20147 ▪ (703) 726-9600
Gainesville ▪ 7531 Somerset Crossing Drive ▪ 20155 ▪ (571) 261-5100