Comprehensive Vision Therapy Center
5300 California Ave., Ste. 210
Bakersfield, CA 93309
(661) 869-2010

Third Party Information Form

If you are bringing a patient into our office that has a history of stroke, head or eye injury and/or is unable to complete their paperwork on their own, please complete this form and return it along with their patient history form.

Patient Name: _____ DOB: _____

Parent, Legal Guardian, or person with Power of Attorney: _____

Relation: _____ Social Security number: _____

Address: _____
_____

Phone number:_____ Alternate phone number:_____

Is this patient adopted? Y N Foster Child? Y N

Anyone other than biological parent with legal custody of a minor, please supply any of the following that apply:

Power of attorney
Legal guardianship papers
Proof of adoption

Authorization to Release Information:

I _____ hereby give, the office of Penelope Suter, O.D., permission to discuss any financial or healthcare issues as it pertains to myself with the following person/s:
Name:_____ Phone: _____ Relation: _____
Name:_____ Phone: _____ Relation: _____
Name:_____ Phone: _____ Relation: _____

Patient signature: _____ Date: _____

All of the above shall stay in affect until this office is notified in writing by the patient, parent, or legal guardian.

Thank you for assisting us in our effort to serve our patients.