First Name _____ MI ___ Last Name _____

[] Mr. [] Mrs. [] Miss [] Ms. [] Male [] Female Nickname _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Home Phone (_____) _____-_____ Alt. Phone (_____) _____-_____ SS# _____-_____-_____

[] Married [] Single []Other [] Full Time Student [] Part Time Student Spouse/Parent _____

Email Address _____

PRIMARY INSURANCE INFORMATION

Vision Insurance _____ Member's Name _____

Member's Date of Birth _____ ID# _____ Group # _____

Employer/Occupation _____

Relationship to Patient [] Self [] Spouse [] Child [] Other

SECONDARY INSURANCE INFORMATION

Vision Insurance _____ Member's Name _____

Member's Date of Birth _____ ID# _____ Group # _____

Employer/Occupation _____

Relationship to Patient [] Self [] Spouse [] Child [] Other

INSURANCE SIGNATURE ON FILE: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance an/or Medicare benefit, and I authorize payment of these benefits directly to my doctor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release the Centers for Medicare and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage my signature authorizes release of the about medical information to the insurer or agency shown, and authorizes my doctor as my agent above. I will be responsible for co-payments and payments for non-covered services.

Signature _____ Date _____

JOHN C LAWYER, O.D.

EXHIBIT 5

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, John C. Lawyer, O.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to John C. Lawyer O.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing the consent. John C. Lawyer, O.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John C. Lawyer, O.D. at 4023 E. Sunset Rd, Henderson, NV 89014. With my consent, John C. Lawyer, O.D. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others. With my consent, John C. Lawyer, O.D. may mail to my home or other designated locations any items that assist John C. Lawyer, O.D. in carrying out TPO, such as reminder cards and patient statements as long as they are marked Personal and Confidential. With my consent, John C. Lawyer, O.D. may fax to my home or other designated locations any items that assist John C. Lawyer, O.D. in carrying out TPO, such as reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that John C. Lawyer, O.D. restrict how it uses or discloses my restrictions, but if it does it is bound by this agreement. By signing this form, I am consenting to John C. Lawyer, O.D.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that John C. Lawyer, O.D. has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John C. Lawyer, O.D. may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Patient's Name	Date

MEDICAL HISTORY

General Heath _____ Family Doctor _____ Last visit: _____

Current Medications: _____

Allergies [] Yes [] No List _____

Do you have problems with any of these systems?

	Personal	Family		Personal	Family		Personal	Family
Gastrointestinal	Yes/No	Yes/No	Ear/Nose/Throat	Yes/No	Yes/No	Cardiovascular	Yes/No	Yes/No
Respiratory	Yes/No	Yes/No	High Blood Pressure	Yes/No	Yes/No	Headaches	Yes/No	Yes/No
Nervous	Yes/No	Yes/No	Allergic/Immunologic	Yes/No	Yes/No	Urinary	Yes/No	Yes/No
Muscles/Bones	Yes/No	Yes/No	Endocrine [glands]	Yes/No	Yes/No	Mental	Yes/No	Yes/No
Blood/Lymph	Yes/No	Yes/No	Macular Degeneration	Yes/No	Yes/No	Glaucoma	Yes/No	Yes/No
Cataracts	Yes/No	Yes/No	Retinal Detachment	Yes/No	Yes/No	Diabetes	Yes/No	Yes/No

Please Explain _____

_____