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HEALTHCARE PROXY

I, patient _____, date-of-birth _____, who can be reached at phone number (_____) _____, am granting permission for the Office of Dr. Andrew Pearle to communicate with someone other than myself in regards to my medical care. This signed authorization permits the following person(s) to make appointments or schedule surgery on my behalf, discuss my medical condition, and make billing or insurance inquiries. Please be advised this proxy must be able to provide 3 patient identifiers (i.e. your name, DOB & home address)

Representative #1

Name: _____

Relation to you: _____

Telephone: _____

Fax: _____

Email: _____

Representative #2

Name: _____

Relation to you: _____

Telephone: _____

Fax: _____

Email: _____

_____
(PRINT) Patient Name & DOB

_____
(PRINT) Parent/Guardian Name if applicable

_____
SIGNATURE

_____
Date