

Please Print Clearly

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please mail this form to:**

Optic Identification Technology Systems, Inc.  
P.O. Box 970320  
Coconut Creek FL 33097-0320

**REMEMBER:**  
to sign the form  
using a medium  
black or blue  
ballpoint pen.

# INFORMATION FORM

This form will be  
microfilmed exactly  
as we receive it, so  
please be as  
accurate as  
possible.



Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_  
Pacemaker: Yes \_\_\_ No \_\_\_      Dentures: Yes \_\_\_ No \_\_\_  
Organ Donor: Yes \_\_\_ No \_\_\_      +      Contact Lenses: Yes \_\_\_ No \_\_\_  
Insurance Carrier: \_\_\_\_\_  
Insurance Carrier Phone: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Health Problems: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Permission to treat in an emergency: Yes \_\_\_ No \_\_\_  
Signature X: \_\_\_\_\_  
Date: \_\_\_\_\_