PUZIO
eyecare associates

MR. MRS. MS. DR. REV. Name: _____Date of Birth:_____

Mailing Address:_____

Phone Number:_____CellPhone:_____Email:_____

Parent/Guardian Name: _____ Primary Care Physician Name:_____

Emergency Contact Name/Phone Number:_____

Primary Insurance: _____ Name of Insured:_____

ID #:_____ Group #:_____

Secondary Insurance:_____ Name of Insured:_____

ID #:_____ Group #:_____

Vision Insurance:_____ Name of Insured:_____

ID #:_____ Group #:_____

I prefer to be contacted by: EMAIL HOME TELEPHONE CELL PHONE TEXT MESSAGE

I authorize Puzio Eye Care to leave a message with any important health information. YES or NO

I authorize Puzio Eye Care to disclose my past, present and future protected health information, including contact lenses, glasses and copies of prescriptions to the following people:

_____

I authorize Puzio Eye Care to release any medical information to medical providers who request it.

YES or NO

I acknowledge that I was offered a copy of the Notice of Privacy Practices at Puzio Eye Care Associates.

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances/or amounts for services not covered by insurance carrier. If my insurance is a managed care plan requiring a referral from my Primary Care Provider (PCP), I understand that if I do not obtain this referral or if my PCP will not provide one, I will be responsible for any and all charges incurred during my treatment.

Signature:_____Print Name:_____Date: ____/____/____