PUZIO
eyecare associates

PATIENT INFORMATION

Today's Date: _____

MR. MRS. MS. DR. REV. Name: _____ Gender: _____
Date of birth: _____ Patient SSN: _____
Mailing Address: _____
_____
Phone Number: _____ Cell Phone: _____
Email: _____ Preferred method of communication: _____

Preferred Language: _____ Race: _____ Ethnicity: _____
Primary Care Physician Name: _____
Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Parent/Guardian Name: _____
Emergency Contact Name/Phone Number: _____

Please circle reason for visit: Routine Examination Contact Lens Examination Emergency Other

Who may we thank for referring you to us? _____
Did another doctor refer you to us? _____

INSURANCE INFORMATION

Medical Insurance: _____ Name of Insured: _____
ID #: _____ Relationship of Insured: _____

Secondary Insurance: _____ Name of Insured: _____
ID #: _____ Relationship of Insured: _____

Vision Insurance: _____ Name of Insured: _____
ID #: _____ Relationship of Insured: _____ DOB: _____

AUTHORIZATIONS

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

I authorize Puzio Eye Care to release any medical information to providers who request it YES or NO

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

_____

PRIVACY PRACTICES for HEALTH INFORMATION

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 deductible, co-insurances/or amounts for services not covered by my 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.

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

I/we hereby authorize Puzio Eye Care to administer procedures as may be necessary for proper health care.

Patient/Guardian Signature: _____ Print Name: _____ Date: _____

Matthew S. Puzio, O.D. **Elizabeth T. Potvin, O.D.** **Matthew J. Philibin, O.D.**

HARWICH 119B Route 137 P.O. Box 1661 East Harwich, MA 02645 ■ 508.432.3444 508.432.3401 fax
DENNIS 860 Route 134, Unit 8 P.O. Box 1412 South Dennis, MA 02660 ■ 508.394.2211 508.398.4471 fax

www.puzioeyecare.com