

Puzio EyeCare Associates - Welcome to Our Office

Please fill this out prior to your appointment and bring it with you at your scheduled time

Patient's Name Mr. Mrs. Ms. Dr. Rev. _____

Date of Birth ____/____/____ Age _____

Street Address _____

Mailing Address _____

Parent / Guardian: _____ Physician's Name: _____

Home Ph. # _____ Day-Time Ph. # _____ Cell Ph. # _____

May we contact you by email? Yes No Email Address _____

Last Eye Examination _____ Last Health Examination _____

Adults

Retired Occupation _____

Activities: _____

Students

School _____ Grade _____ Nurse _____

Activities _____

How did you hear about our office? Phone Book Newspaper Radio Internet Friend

If it was a friend, who may we thank for referring you to us? _____

Reason for today's examination... Routine Examination Contact Lens Examination Emergency

Insurance

Please specify applicable insurance carrier(s) below. Present insurance cards to our staff for a photocopy.

Primary: _____ Secondary: _____

Preferred method of payment... Cash Check MasterCard / Visa Discover

Payment Policies: Examination fees / co-pays...due in full on the date of the examination.
Eyewear and contact lenses... 50% due upon order. Balance due in full upon pickup.

PATIENT'S SIGNATURE REQUIRED

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 dependants. I understand I am responsible for any deductibles, co-insurances/or amounts for services not covered by insurance carrier.

I have read & understand the above policy... _____ Date: ____/____/____